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No. 93-77

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1993

LINDA RANDOL AND BRUCE RANDOL, JR.,

Petitioners,

versus

MID-WEST NATIONAL LIFE INS. CO. OF TENNESSEE,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. To what degree, if any, must an employer engage in administrative responsibilities with respect to the provision of benefits to employees in order to "establish or maintain" an "employee welfare benefit plan" within the meaning of ERISA, 29 U.S.C. § 1002?

2. Is the employer's intent relevant to the determination of whether the employer has "established or maintained" an ERISA plan?

3. Does an employer, which has no desire or intention to provide its employees with an employee welfare benefit plan, nevertheless "establish or maintain" an ERISA plan when he (1) allows an insurance company, which sold *individual* policies of insurance to two of his employees, to automatically debit the policy premiums from his business checking account, and (2) deducts the full amount of the policy premiums from the two employees' paychecks except $75.00 per month?

RULE 29.1 STATEMENT

Mid-West National Life Insurance Company of Tennessee is a subsidiary of United Insurance Companies, Inc.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners, Linda Randol and Bruce Randol ("the Randols"), respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

OPINIONS BELOW

The Court of Appeals for the Eleventh Circuit affirmed the district court's finding of preemption by ERISA. *Randol v. Mid-West National Life Ins. Co.*, 987 F.2d 1547 (11th Cir. 1993) (appended hereto, *infra*, 1a-11a). The Eleventh Circuit possessed jurisdiction under 28 U.S.C.

§§ 1441 and 1291. The United States District Court for the Southern District of Alabama did not publish its opinion, but it is appended hereto (*infra*, 12a-13a). The district court possessed jurisdiction under 28 U.S.C. § 1332 (diversity) and, by its ruling, § 1331 (federal question).

JURISDICTION

The Eleventh Circuit rendered its judgment on April 12, 1993, giving this Court jurisdiction under 28 U.S.C. § 1254.

STATEMENT OF THE CASE

A. Course of Proceedings Below

This case arises out of a dispute over medical insurance coverage. Respondent Mid-West refused to provide coverage for complications arising out of Mrs. Randol's delivery of a child. The Randols sued Mid-West in an Alabama state court alleging breach of contract, bad faith, and fraud. The complaint sought both compensatory and punitive damages, and demanded a trial by jury. Mid-West removed the action to federal court alleging jurisdiction based upon diversity of the parties and federal question under ERISA. The district court held that the Randols' insurance policy constituted an ERISA plan and that their state law claims were preempted. The district court dismissed the Randols' state claims and struck their demand for a jury trial. The Eleventh Circuit Court of Appeals affirmed the district court's judgment.

B. Facts Pertaining to ERISA Issue

The facts relevant to the ERISA preemption issue are not in dispute. App. at 2a. Bruce Randol was employed as a tire-changer at Ed's Tire Center, a "mom and pop"-type corporation which sold and repaired tires. The business was wholly owned and operated by Edward Hurt. Hurt employed a total of three people.

Hurt did not offer his employees any insurance benefits. In March 1988, the Randols *individually* decided to purchase medical insurance for themselves because they were planning to have a child. Mr. Randol was actively seeking such coverage when he met Mid-West's agent, Daniel Johnson. Johnson initially approached Hurt about whether Ed's Tire Center – the corporation – was interested in purchasing group insurance for its employees. Hurt responded that "we as a corporation were not interested in group insurance", but he allowed Johnson to speak with his workers about buying their own insurance. Johnson then met with Randol at the shop during business hours and, following their conversation, Randol and another employee decided to buy medical insurance from Mid-West.

Hurt did not participate in Johnson's conversations with his employees. However, after Randol and the other employee decided to buy the insurance, Johnson asked Hurt if Mid-West could draw the premium payments from Ed's Tire Center's bank account. According to Hurt:

> "[T]he only part that I got involved in the conversation was that – when he [Johnson] says, well, we will have to draft your bank account

> . . . to pay for this insurance . . . And I objected to this. I don't like anybody touching my bank account . . . But I decided that if the employees – are willing to go ahead and get insurance for themselves, I would go along with that side of it. . . . And I allowed them to draft my bank account."

Hurt authorized the automatic premium payments with the understanding that he would deduct *most* of the insurance premiums from the two employees' paychecks. Although Randol and the other employee had already committed to buying the insurance for themselves, Hurt was persuaded to help with the monthly premiums by contributing $75 per month for each employee (i.e., Hurt deducted the full amount of the monthly premium, less $75, from each employee's paycheck).

Despite the contribution, it is undisputed that Hurt "did not intend to set up an insurance plan or an employee benefit program." App. at 3a. As Hurt put it: "I had no intention of setting up an insurance plan" and "had no intention of making it any kind of employee benefit." Instead, Hurt made the contribution "in order to keep people off my back about getting group insurance". Hurt testified that he made it clear to Johnson that he "didn't want to have any involvement in the insurance except for the payment of the premium." Rather, the arrangement was purposefully "set up so [I] had to do virtually nothing . . . [except] check [my] statement once a month to see that the premium had been deducted." As far as Hurt was concerned, the corporation was not buying this insurance, each employee was buying his own.

It is undisputed that Johnson never made the slightest mention of ERISA to anyone. Neither Johnson or

anyone else at Mid-West knew *anything* about ERISA at the time (even what the letters "E*R*I*S*A*" represent). There is not a single reference to ERISA anywhere in any of the insurance papers (i.e., the brochure, the application, the policy, etc.). No one at Mid-West informed Hurt about ERISA's requirements or how to comply, and Hurt, consequently, made no such efforts. No one ever suggested that Ed's Tire Center had *any* administrative, fiduciary, reporting or other duties with respect to this insurance. In fact, the evidence established that Hurt would have rejected the automatic payment proposal *in toto* if he had known about ERISA, its responsibilities and its consequences.

A representative of Mid-West testified that although the policy was considered a "group policy," the only underwriting criterion was the medical eligibility of the individual to be insured. Mid-West regarded the Randols as individual applicants for insurance and it never sought or received any application from Ed's Tire Center. Mr. Randol's application mentioned Ed's Tire Center only for the purpose of noting his place of employment.

Hence, Mr. Randol's policy of insurance was not considered an "employee welfare benefit plan" even by Mid-West. Ed's Tire Center was never even sent a copy of the insurance policy. There was no correspondence between Mid-West and Ed's Tire Center. The only involvement that Ed's Tire Center had with Mr. Randol's insurance policy was that the policy premiums were automatically debited from the corporation's account. Mid-West did not know or care whether Ed's Tire Center was actually paying the premiums or whether the full amount of the premiums were being deducted from Mr. Randol's

paychecks. If Ed's Tire Center had failed to make a premium payment, Mid-West would have contacted the Randols rather than the company about the delinquency. When the policy was canceled, Mid-West sent the refund check directly to the Randols.

In short, Mid-West did nothing other than sell a garden variety group insurance policy to Mr. Randol. Mr. Randol's employer got involved as an afterthought. Because Mid-West was as ignorant of ERISA as was Hurt, Mid-West made absolutely no effort to comply with its requirements. Nobody involved had any idea that ERISA even existed. There were no written plan documents, no summary plan descriptions, no disclosures, no reports, no filings with the Department of Labor, no participation, vesting, or benefit accrual standards, no minimum funding standards, no trusts, no trustees, fiduciaries, no administrators, and no bonds – all of which are required by ERISA. *See, e.g.*, 29 U.S.C. §§ 1001 - 1145. Nevertheless, the Eleventh Circuit held that Ed's Tire Center had "maintained" an employee welfare benefit plan within the meaning of ERISA and that, consequently, the Randols' state law claims were preempted.

C. The Eleventh Circuit's Decision

ERISA defines an employee welfare benefit plan as:

> "Any plan, fund or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical or hospital

> care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . . "

29 U.S.C. § 1002(1). In its decision, the Eleventh Circuit noted that "[t]his statutory definition of an ERISA employee welfare benefit plan has been fleshed out through a combination of agency regulations and case law." App. at 5a.

The Eleventh Circuit recognized that the Department of Labor, under the authority conferred by Congress, 29 U.S.C. § 1135, promulgated "safe harbor" regulations, 29 C.F.R. § 2510.3-1(j)(1), which provide specific guidelines concerning whether group insurance offered to employees through their place of employment qualifies as employee welfare benefit plans under ERISA.[1] The court

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[1] The "safe harbor" provisions provide:

"**Certain Group or Group-Type Insurance Programs.**

"For purposes of Title I of the Act in this Chapter, the term 'employee welfare benefit plan' and 'welfare plan' shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which:

" '(1) No contributions are made by an employer or employee organization;

" '(2) Participation in the program is completely voluntary for employees or members;

" '(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs, and to remit them to the insurer; and,

" '(4) The employer or employee organization receives no consideration in the form of cash or

found that the safe harbor provisions do not apply to this case since Ed's Tire Center contributed $75.00 per month towards each of the two employees' premium payments. App. at 6a.

The Randols argued that while the "safe harbor" regulations do serve to *exclude* certain plans from ERISA, the type of employer activity identified within the regulations represent important factors the court should examine in determining whether an employer has "established or maintained" an ERISA plan. In other words, the Department of Labor has excluded group insurance from the definition of an ERISA plan where the employer merely acts as a conduit between its employees and the insurance company, i.e., (1) the employer makes no contributions, (2) participation in the group insurance is completely voluntary for the employees, (3) the employer does not endorse the insurance, (4) the employer's role is simply to collect the premiums through payroll deductions and to remit them to the insurer, and (5) the employer receives no consideration from the insurer other than reasonable compensation for administrative services rendered in connection with payroll deductions. Since the Department of Labor has determined that an employer which does *not* engage in these activities has

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otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with the payroll deductions or dues checkoffs.' "

not "established or maintained" an ERISA plan, the Randols argued that an employer would have to engage in these types of activities (at least in the group insurance context) in order to establish or maintain an ERISA plan. However, rather than considering the "safe harbor" factors, the Eleventh Circuit treated them as an "exception" and did not otherwise consider them in evaluating Ed's Tire Center's conduct. App. at 6a.

The safe harbor regulations indicate that even though an employer has substantial and meaningful involvement in the collection and payment of premium monies for its employees' group insurance, this is not the type of activity that constitutes the establishment or maintenance of an ERISA plan. The Randols argued that even though Ed's Tire Center contributed premium monies, it otherwise engaged in none of the activities identified by the safe harbor provisions and therefore did not undertake the types of administrative responsibilities which ERISA was designed to regulate.[2] The Randols argued that when an employer engages in only one of the safe harbor factors, (i.e., merely contributes some premium money), the reviewing court should thoroughly examine all of the

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[2] During discovery, the parties stipulated that three of these four criteria are satisfied in the instant case. Participation in the program was completely voluntary for employees of Ed's Tire Center; Ed's Tire Center did not endorse the insurance; and, Ed's Tire Center received no consideration in connection with the insurance or for payroll deductions. The only safe harbor factor missing in this case is "no contributions [were] made by [the] employer", i.e., the $75.00 contribution made by Ed's Tire Center.

facts and circumstances before determining that the employer established or maintained any plan. Although this is the approach followed by numerous other federal and state courts,[3] the Eleventh Circuit rejected it.

Instead, the Eleventh Circuit applied a test which emphasizes the existence of a "plan" and makes little or no inquiry into the employer's conduct or intent. The court followed the test it first enunciated in *Donovan v. Dillingham*, 688 F.2d 1367, 1374 (11th Cir. 1982), which is set out below:

> "In determining whether a plan, fund or program (pursuant to a writing or not) is a reality, a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.

App. at 7a. Applying this test, the court found that an ERISA plan existed because:

> "The intended benefits are, of course, the medical care provided under the insurance policy. The class of beneficiaries is composed of the workers who chose to purchase the group health insurance. The source of financing is the employee-paid premium supplemented by the monthly $75 employer contribution. Finally, the procedures for receiving benefits are those set out in the insurance policy."

App. at 7a-8a. Importantly, the court observed, as it had in *Donovan*, that "there is no requirement that the

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[3] *See* discussion, *infra*, Part C, pp. 20-28.

employer play any role in administering the plan in order for it to be deemed an ERISA employee welfare benefit plan." App. at 8a, n.5.

In reaching its decision, the court made no attempt to distinguish conflicting precedent from this Court and its sister circuits,[4] nor did it explain how Ed's Tire Center's involvement was any more significant (aside from the $75 contribution) than the type of employer involvement excluded from the definition of a plan by the safe harbor regulations. The Randols seek review to resolve these conflicts.

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[4] The court did attempt to distinguish *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), cert. denied, 101 S.Ct. 1739 (1981), an opinion which is binding in the Eleventh Circuit. App. at 9a, n.7. Curiously, the court distinguished *Taggart* on the ground that the employer "did not subsidize purchase of the policy." However, the employer in *Taggart did* purchase the policy. The *Taggart* opinion itself states: "[C]onsidering the history, structure and purposes of ERISA, *we cannot believe that the Act regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits.*" *Id.* at 1208.

REASONS FOR GRANTING THE PETITION

> "The ERISA quicksand is fast swallowing up everything that steps in it or near it. The morass serves as the stage for the theater of the absurd."[5]

There are "special and important reasons" for granting the instant petition. S. Ct. R. 10.1. The purpose behind Congress's passage of ERISA was to provide employers "a uniform set of administrative procedures governed by a single set of regulations." *Ft. Halifax Packing Co., Inc. v. Coyne*, 481 U.S. 1, 10-11 (1987). Yet, in the nineteen years since its passage, anything but uniformity has developed concerning the critical threshold determination of what an employer must do to "establish or maintain" an ERISA plan. This Court has never directly spoken to this critical issue. The various state and federal appellate courts have developed conflicting approaches for analyzing this issue. The lower courts (like employers, insurers, and lawyers) need guidance from this Court. Without it, the uniformity envisioned by Congress may take another twenty years.

A. THE COURT SHOULD GRANT THE PETITION BECAUSE THE ELEVENTH CIRCUIT HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT

The question presented by this case is whether, in light of the purposes for which ERISA was enacted and

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[5] *Jordan v. Reliable Ins. Co.*, 694 F.Supp. 822, 827 (N.D. Ala. 1988).

the safe harbor regulations promulgated by the Department of Labor, an employer which does no more than contribute premium monies towards its employees' individual purchases of insurance has "established or maintained" an ERISA plan. The statute is conspicuously silent on how the "established or maintained" issue should be analyzed. While this Court's prior opinions have shed some light upon the "established and maintained" language, it has not directly addressed this important issue, and the lower courts, both state and federal, have developed conflicting approaches.

This case presents the Court with a remarkable opportunity to provide the guidance so desperately needed by lowers courts, employers, insurers, and lawyers involved in this arena. With this case, the Court can settle the common and difficult problem which arises under ERISA when an employer undertakes limited responsibilities in connection with its employees' medical insurance. At the same time, the Court can eliminate the conflict which exists between the Eleventh Circuit's approach in this case and the analysis embodied in the Fifth Circuit's opinion in *Hansen v. Continental Insurance Company*, 940 F.2d 971 (5th Cir. 1991), as well as opinions delivered by other circuits.

As the law stands, employers and insurers are subject to different applications of the "established or maintained" language depending upon the circuit in which they find themselves. An employer with employees in Alabama and Mississippi, for example, is subject to two different tests for determining whether a "plan" has been

"established or maintained".[6] The same is true of insurers which, like Mid-West, may have insureds like the Randols located all over the country. There are thousands of small "mom-and-pop" employers who may be similarly situated to Ed Hurt – they know nothing of ERISA and its obligations, and are not told of ERISA by insurance salesmen and, yet, by merely "chipping in" to help employees purchase their own insurance, they are ensnared into ERISA's intricate web of statutes, regulations, and conflicting judicial interpretations. This is particularly alarming since non-compliance with ERISA's requirements can result in criminal sanctions.[7] The time is ripe for clear guidance from this Court.

B. THE COURT SHOULD GRANT THE PETITION BECAUSE THE ELEVENTH CIRCUIT HAS DECIDED A FEDERAL QUESTION IN A WAY THAT CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT

This Court has recognized that an employer which undertakes to "establish or maintain" an ERISA plan is "faced with the task of coordinating complex administrative activities." In this case, however, the Eleventh Circuit, building upon an earlier holding "that there is no requirement that the employer play *any role* in administering the plan in order for it to be deemed an ERISA

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[6] Alabama is in the Eleventh Circuit and Mississippi is in the Fifth Circuit.

[7] 29 U.S.C. § 1331; *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208, 1211 (5th Cir. 1980), *cert denied*, 450 U.S. 1030 (1981).

employee welfare benefit plan," App. 8a, n. 5 (emphasis added), found that the employer had unwittingly created an ERISA plan even though he possessed strong intentions to the contrary and his involvement in the putative plan was ministerial. The Eleventh Circuit's analysis conflicts with two decisions from this Court, *Ft. Halifax Packing Co., Inc. v. Coyne*, 481 U.S. 1 (1987) and *Massachusetts v. Morash*, 490 U.S. 107 (1989).

In *Ft. Halifax*, the Court described the types of employer abuses which gave rise to Congress' promulgation of ERISA. The Court implicitly recognized that establishing or maintaining a plan requires a *conscious and knowing* undertaking by an employer to engage in administrative functions:

> "An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in different states. A plan would be required to keep certain records in some states but not in others; to make certain benefits available in some states but not in others; to process claims in a certain way in some states but not in others; and to comply

with certain fiduciary standards in some states but not in others."

* * *

"It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan would be governed by only a single set of regulations."

* * *

"[C]ongress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. *This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation. It is for this reason that Congress preempted state laws relating to plans, rather than simply to benefits. Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patch-work scheme of regulation.*"

Id. at 10-11 (emphasis added). The Court concluded *"to do little more than write a check hardly constitutes the operation of a benefit plan."* *Id.* at 12. Moreover, the mere "decision to extend benefits is not the establishment of a plan or

program". *Id.* at 12, n.6. Under *Ft. Halifax*, the ministerial act of allowing a business' checking account to be debited for premium payments and contributing some money towards the *employee's* purchase of insurance is insufficient to conclude that the employer established or maintained a plan.

The Eleventh Circuit's opinion ignores the principles recognized in *Ft. Halifax*. Ed's Tire Center was in no way involved with the types of administrative concerns identified in *Ft. Halifax*. Mr. Hurt did not make a "commitment systematically to pay certain benefits, undertake a host of obligations such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, or keeping appropriate records in order to comply with the applicable reporting requirements". *Ft. Halifax*, at 10-11. There were no "benefits whose provision by nature require(d) an ongoing administrative program to meet the employer's obligation." *Id.* Hurt did not consciously and knowingly undertake to engage in "the task of coordinating complex administrative activities." *Id.*

To the contrary, Hurt testified emphatically that he "did not intend to set up an insurance plan or an employee benefit program." App. at 3a. Hurt testified that he made it clear to Johnson that he "didn't want to have any involvement in the insurance except for the payment of the premium." The arrangement was purposefully set up so he had to do virtually nothing except check his bank statement once a month to see that the premium had been deducted.

Likewise, in *Massachusetts v. Morash, supra,* the Court determined that an employer's agreement to pay severance benefits did not implicate the concerns for which ERISA was enacted:

> "In enacting ERISA, Congress' primary concern was the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from accumulated funds . . . To that end, it established extensive reporting, disclosure, and fiduciary duty requirements to ensure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator. *Because ordinary vacation payments are typically fixed, due at known times, and do not depend on contingencies outside the employee's control, they present none of the risks that ERISA is intended to address. If there is a danger of defeated expectations, it is no different from the danger of defeated expectations of wages for services performed – a danger Congress chose not to regulate in ERISA."*

Id. at 115 (emphasis added). In this case, there were no "risks of defeated expectations" or "contingencies outside the employee's control" any "different from the danger of defeated expectations of wages for services performed." The premium payments were automatically debited from Ed's Tire Center's business account. These payments were "fixed", "due at known times" and not dependent "on contingencies outside the employee's control."

Clearly, under *Ft. Halifax* and *Morash,* Ed's Tire Center did not undertake the kind of administrative responsibilities ERISA was designed to regulate. Instead, all administrative responsibilities were borne by Mid-West

solely as an insurer and not as an "administrator" for an employee welfare benefit plan.

ERISA's regulatory obligations presuppose an employment nexus between the benefits provider and the beneficiary of those benefits. As noted by the Fifth Circuit in *MDPhysicians & Associates v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir. 1992), it is not enough for a benefit supplier to simply provide benefits through some plan to people who happen to be employed; instead, they must be "tied by a common economic or representation interest unrelated to the provision of benefits." *Id.*, citing, *Wisconsin Educ. Ass'n Ins. Trust v. Iowa State Bd.*, 804 F.2d 1059, 1063 (8th Cir. 1986). Despite these holdings, the Eleventh Circuit concluded that there need be *no* employer involvement in administration. The court based this conclusion on the proposition that the employer may shift the administrative responsibilities to some other entity, like an insurer. As the court noted in this case, "a commercially purchased insurance policy under which the procedures for receiving benefits are all dictated by the insurance carrier can constitute a plan for ERISA purposes."[8] However, absent some employer conduct which

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[8] The court's conclusion presupposes that the *employer* purchases and pays for the insurance policy. In both cases relied upon by the court, App. at 8a, n.5, as authority for this proposition, *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991), *cert. denied*, 112 S.Ct. 2941 (1992) and *Brundage-Peterson v. Compcare Health Services, Inc. Corp.*, 877 F.2d 509 (7th Cir. 1989), the employers purchased and had control over the policies. Here, Ed's Tire Center purchased and had control over nothing. Instead, Mr. Randol purchased the insurance; Ed's Tire Center merely helped defray the cost of this purchase. As the Seventh Circuit recognized in *Brundage-Peterson, supra*, "if

indicates some *control* over the provision of insurance benefits, this approach transforms ERISA from legislation which regulates employer conduct to legislation which regulates insurance company conduct. This responsibility was expressly left to the states by the savings clause.[9]

In light of Congress' desire for uniformity, the disparity between this Court's decisions and that of the Eleventh Circuit should be resolved now. So fundamental a determination should not be left to the common law to develop through the years, particularly since so many people are potentially affected on a nationwide scale.

C. THE COURT SHOULD GRANT THE PETITION BECAUSE THE ELEVENTH CIRCUIT HAS RENDERED A DECISION IN CONFLICT WITH DECISIONS OF OTHER UNITED STATES COURTS OF APPEALS ON THE SAME MATTER

The Eleventh Circuit's test for whether an employer has established or maintained an ERISA plan conflicts with decisions rendered by the First, Fifth, Seventh and Tenth Circuits, as well as those of several federal district courts and state appellate courts.

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an employer offers no welfare benefit plan to its employees but leaves each employee free to shop around for his or her own insurance, ERISA does not apply." *Id.* at 510.

[9] Congress expressly intended that ERISA would not supplant or displace the centuries of state-based common law principles regulating the insurance industry. 29 U.S.C. § 1144(b)(2)(A)("nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance").

The Eleventh Circuit's *Donovan*[10] test focusses on the wrong factors. The Eleventh Circuit simply asks, 'Is there a plan?'. If the court finds that a 'plan' exists, the court practically presumes that it is an ERISA plan, i.e., that it was "established or maintained" by the employer. The Eleventh Circuit's test emphasizes the existence of a "plan" and makes little or no inquiry into the employer's conduct or intentions.

The safe harbor regulations[11] provide an excellent framework within which to analyze the extent of employer involvement necessary to create a "plan" in the group insurance context. Unfortunately, the Eleventh Circuit refuses to consider the types of factors identified by the safe harbor regulations in deciding whether an employer has "established or maintained" an ERISA plan. In fact, were it not for the safe harbor regulations, under the Eleventh Circuit's approach even an employer which does no more than act as a conduit for premium payments for its employees' group insurance coverage would be subject to ERISA. Instead of drawing guidance from the safe harbor provisions, or otherwise evaluating the

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[10] As noted, in this case the Eleventh Circuit applied the test it enunciated a decade earlier in *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982). In *Donovan*, the court held that an ERISA plan exists "if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits."

[11] 29 C.F.R. § 2510.3-1(j)(1); *see*, discussion *supra*, at pp. 7-11.

extent of the employer's involvement in establishing or maintaining the "plan", the Eleventh Circuit holds that the employer need not have *any* administrative involvement in the provision of group insurance benefits.

The Fifth and other circuits have, either implicitly or explicitly, rejected the Eleventh Circuit's test. Most cases construing the "safe harbor" provisions generally hold that when one or more of the "safe harbor" provisions has not been meet in a given case, the reviewing court must look to the totality of the circumstances to determine whether the employer did, in fact, "establish or maintain" an employee welfare benefit plan.[12] These courts recognize that employer involvement with group insurance is the essence of what ERISA regulates and that the proper focus should be upon the employer, its conduct, and its intentions.

The Fifth Circuit requires that the employer have a meaningful degree of participation in administration of the putative plan and harbor specific intentions to systematically provide benefits to its employees over a long

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[12] *See*, e.g., *Hansen v. Continental Insurance Co.*, 940 F.2d 971 (5th Cir. 1991); *Kidder v. H&B Marine, Inc.*, 932 F.2d 347 (5th Cir. 1991); *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991); *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990); *Wickman v. Northwestern National Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990); *Cote v. Dunham Life Ins. Co.*, 754 F. Supp. 18 (D. Conn. 1991); *Foxworth v. Dunham Life Ins. Co.*, 745 F. Supp. 1227 (S.D. Miss. 1990); *Terry v. Protective Life Ins. Co.*, 717 F. Supp. 1203 (S.D. Miss. 1989); *Ellington v. Metropolitan Life Ins. Co.*, 969 F. Supp. 1237 (S.D. Ind. 1988); *Baucom v. Pilot Life Ins. Co.*, 674 F. Supp. 1175 (N.D.N.C. 1987); and, *Hamberlin v. VIP Ins. Trust*, 434 F. Supp. 1196 (D. Ariz. 1977).

term in order to establish and maintain an ERISA plan. In *Hansen v. Continental Insurance Co.*, 940 F.2d 971 (5th Cir. 1991), the Fifth Circuit held that a court must look first to the safe harbor provisions to determine whether the putative plan is excluded. If the purchase of insurance is not excluded by the "safe harbor" criteria, the Fifth Circuit examines the Eleventh Circuit's *"Donovan"* factors to determine whether a "plan" exists. According to the Fifth Circuit: "The fact that a plan exists [under *Donovan*], however, does not necessarily mean that the plan is an ERISA plan." *Id.* at 977. Instead:

> "As the Eleventh Circuit noted, 'an employer or employee organization, . . . and not individual employees . . . must establish or maintain the plan, fund or program.' . . . In addition, as noted above, the statute requires that the employer have established or maintained the program with a purpose of providing certain benefits to its employees.
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> *"To determine whether an employer 'established or maintained' an employee benefit plan, 'the court should focus on the employer and [its] involvement with the administration of the plan.'* . . . Thus, if an employer does no more than purchase insurance for her employees, and has no further involvement with the collection of premiums, administration of the policy, or submission of claims, she has not established an ERISA plan. . . . As this Court explained in one of its early cases on the subject:
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> > '[c]onsidering the history, structure, and purposes of ERISA, we cannot believe that the Act regulates bare purchases of health insurance where . . . the purchasing

> employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy or its benefits.' . . .
>
> "In addition to some meaningful degree of participation by the employer in the creation or administration of the plan, the statute requires that the employer have had a purpose to provide health insurance, accident insurance, or other specified types of benefits to its employees. 29 U.S.C. § 1002(1). Thus, the Court has held that, in a case involving the purchase of a group insurance policy, *the evidence must show that the employer had an 'intent to provide its employees with a welfare benefit program through the purchase and maintenance of the group insurance policy.' . . .* "

Id. at 977-78 (emphasis added; citations omitted). Thus, unlike the Eleventh Circuit, the Fifth Circuit examines the safe harbour factors by focusing on "the employer and [its] involvement in the administration of the plan."

The Fifth Circuit's rationale in *Hansen* began with its decision in *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 101 S.Ct. 1739 (1981). In *Taggart*, the court rejected the Secretary of Labor's contention that the employer's subscription to a multiple employer trust constituted the establishment of an ERISA "plan". The court reached this conclusion because the employer was not involved to any meaningful degree with ownership, administration or control of the putative plan:

> "The supposed Taggart 'plan' has no assets and is liable for no benefits. There is nothing to be

> placed in trust, so there is no trust. The corporation did no more than make payments to a purveyor of insurance, patently for tax reasons. There simply exist no assets for ERISA's statutory safeguards to protect."

Id. at 1208 (citations deleted). In *Taggart*, the employer actually paid for the purchase of insurance.[13] Nevertheless, the Fifth Circuit concluded that this, without more, does not justify the conclusion that an ERISA plan has been created.

Here, unlike *Taggart*, Ed's Tire Center purchased nothing, but simply contributed toward the *employees'* purchase of insurance. Under *Taggart's* rationale, no "plan" was ever "established or maintained" by Ed's Tire Center. Under the Fifth Circuit's approach, Ed's Tire Center simply did not sufficiently participate in the administration of the group insurance to create an ERISA plan.[14]

The Eleventh Circuit rejected, without explanation, the Randols' suggestion it follow the Fifth Circuit's approach to this issue. The Fifth Circuit's rationale was

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[13] The Eleventh Circuit attempted to distinguish *Taggart* in its opinion. App. at 9a, n.7. Curiously, the court distinguished *Taggart* on the ground that the employer "did not subsidize purchase of the policy." However, the employer in *Taggart did* purchase the policy. The *Taggart* opinion itself states: "we cannot believe that the Act regulates *bare purchases* of health insurance . . . . " *Id.* at 1208.

[14] *Accord, Clark v. Golden Rule Ins. Co.*, 737 F.Supp. 376 (W.D. La.), affm'd, 887 F.2d 1276 (5th Cir. 1989) (when employer does not directly or indirectly own, control, administer, or assume responsibility for the insurance policy or its benefits, no "plan" has been established or maintained).

adopted by the Tenth Circuit in *Peckham v. Gem State National of Utah*, 964 F.2d 1043, 1049 (10th Cir. 1992) ("The 'established or maintained' requirement seeks to ascertain whether the plan is part of an employment relationship by looking at the degree of participation by the employer in the establishment or maintenance of the plan.")[15]

In addition to the Fifth and Tenth Circuits, the Seventh Circuit requires meaningful participation by the employer in the ongoing administration of the putative plan.[16] Still further, the First, Seventh and Ninth Circuits require evidence of an intent by the employer to systematically provide long-term benefits to its employees

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[15] The most recent application of the *Hansen* analysis is *Meredith v. Time Ins. Co.*, 980 F.2d 352, 355 (5th Cir. 1993) ("We have devised a comprehensive test for determining whether a particular plan qualifies as an 'employee welfare benefit plan'; we ask whether a plan: (1) exists; (2) falls within the safe-harbor provision established by the Department of Labor; and (3) satisfies the primary elements of an ERISA 'employee benefit plan' – establishment or maintenance by an employer intending to benefit employees. If any part of the inquiry is answered in the negative, the submission is not an ERISA plan.").

[16] *See, Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509 (7th Cir. 1989); *Otto v. Variable Annuity Life Ins. Co.*, 814 F.2d 1127 (7th Cir. 1987), *cert. denied*, 486 U.S. 1026 (1988)(remittance of designated premiums to annuity supplier is ministerial act, unaffected by Department of Labor's regulations, and not enough to constitute establishing or maintaining plan).

through a plan.[17] Conflicts also exist among the federal district courts[18] and several state courts of appeal.[19]

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[17] *See, Fischer v. United Chambers Administrators, Inc.*, 908 F.2d 976 (9th Cir. 1990)(unpublished); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989); *Wickman v. Northwestern Nat. Life Ins. Co.*, 908 F.2d 1077, 1083 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990)("the crucial factor in determining if a 'plan' has been established is whether the purchase of the insurance policy constituted an expressed intention by the employer to provide benefits on a regular and long-term basis"); *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 741 (7th Cir.), *cert. denied*, 107 S.Ct. 3188 (1987), ("the corporation has, via a written agreement, established its intent to potentially provide benefits to all salaried employees").

[18] E.g., *Barett v. Insurance Co. of North America*, 813 F.Supp. 798 (N.D. Ala. 1993); *Baucom v. Pilot Life Ins. Co.*, 674 F.Supp. 1175 (M.D.N.C. 1987); *Sims v. Lumbermen Mutual Casualty Co.*, 789 F.Supp. 781 (S.D. Miss. 1992); *Shaw v. Pottsville Hospital-Warner Clinic*, 1991 WL 117390 (E.D. Pa. 1991) (unpublished); *National Business Association Trust v. Morgan*, 770 F.Supp. 1169 (W.D. Ky. 1991); *McQueen v. Salida Coca-Cola Bottling Co.*, 652 F.Supp. 1471 (D. Col. 1987); *Thomas v. Burlington Industries*, 769 F.Supp. 268 (S.D. Fla. 1991).

[19] For example, in *Sayble v. Blue Cross of So. California*, 208 Cal.App.3d 1108, 256 Cal.Rptr. 820 (Cal.App. 2 Dist. 1989), the court found no plan due to the employer's lack of participation in the administration of the insurance benefits. In rejecting the insurer's claim of ERISA preemption, the court observed:

> *"Due to the lack of participation by Swiss American in the administration of the subject insurance benefit, the regulatory concerns of ERISA are not implicated . . . Because there was no employer-operated plan, there was no potential for employer abuses such as self-dealing, imprudent investing, and misappropriation of plan funds* . . . Therefore, the rationale of ERISA is not served in this fact situation."

These conflicting methods of analysis point out that the uniformity sought by Congress has not yet occurred. By granting the instant petition, the Court could eliminate these conflicts and move a step closer toward achieving the uniformity envisioned by Congress.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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Id. at 825-26 (citations omitted). *Cf., Marshall v. Bankers Life and Cas. Co.*, 282 Cal. Rptr. 151, 161 (Cal. App. 2d Dist. 1991)(court rejected an insurer's effort to use the "illusion" of a putative ERISA plan to deprive plaintiffs "of the benefits of state laws regulating insurer misconduct"); *Hood v. Prudential Ins. Co. of America*, 522 So.2d 265 (Ala. 1988); *Seafarer's Welfare Plan v. Dixon*, 512 So.2d 55 (Ala. 1987); *Sayble v. Blue Cross of So. California*, 208 Cal. App. 3d 1108, 256 Cal. Rptr. 820 (Cal. App. 2 Dist. 1989); *Marshall v. Bankers Life and Cas. Co.*, 2 Cal. 4th 1045, 832 P.2d 573, 10 Cal. Rptr, 2d 72 (Cal. 1992); *Blue Cross/Blue Shield of Florida, Inc. v. Weiner*, 543 So.2d 794 (Fla. App. 4 Dist. 1989); *Golden Bear Family Restaurants, Inc. v. Murray*, 144 Ill. App. 3d 616, 494 N.E.2d 581 (1986).

APPENDIX A

Linda RANDOL and Bruce Randol, Jr., Plaintiffs-Appellants,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE, Defendant-Appellee.

No. 91-7884.

United States Court of Appeals,
Eleventh Circuit.

April 12, 1993.

Appeal from the United States District Court for the Southern District of Alabama.

Before ANDERSON and DUBINA, Circuit Judges, and CLARK, Senior Circuit Judge.

ANDERSON, Circuit Judge:

The question presented in this appeal is whether a health insurance policy obtained by appellant Bruce Randol with the assistance of his employer qualifies as an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1002(1). Plaintiffs-appellants Linda and Bruce Randol sued their insurance carrier, Mid-West National Life Insurance Co. of Tennessee ("Mid-West"), in Alabama state court pleading state law claims of fraud, breach of contract, and bad faith over Mid-West's refusal to cover the costs of medical care required by Linda Randol. Mid-West removed the action to federal court, alleging federal subject matter jurisdiction based on diversity of parties and on the federal question of

whether the state law claims were preempted by ERISA.[1] Following discovery, the district court ruled that the Randols' insurance plan qualifies as an "employee welfare benefit plan," thus bringing the insurance dispute within the regulatory scope of ERISA. As a result, the court dismissed the Randols' state law claims, finding them preempted by the federal statute. The court also struck the Randols' demand for a jury trial, as their remaining cause of action, an ERISA claim, is triable only to a judge. This appeal followed.

I. FACTS

The material facts relevant to the ERISA preemption issue are not in dispute. Bruce Randol was employed as a mechanic at Ed's Tire Center, a small business wholly owned and operated by Edward Hurt. Hurt employed a total of three people. Before March 1988, Hurt did not offer his employees any insurance benefits. In March 1988, Linda and Bruce Randol decided to purchase major medical insurance for themselves because they were planning to have a child. Mid-West's agent, Daniel Johnson, had originally approached Hurt about buying group coverage for his employees. Hurt was not interested but agreed to allow Johnson to speak with his workers. Bruce Randol subsequently met with Johnson at the Tire Center

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[1] Assertion of an ERISA preemption defense suffices to establish federal question subject matter jurisdiction under 28 U.S.C. § 1331, thus permitting a state court defendant to remove the case to federal court pursuant to 28 U.S.C. § 1441. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987).

during business hours and, following their conversation, Randol and another employee decided to purchase medical insurance from Mid-West.

Hurt testified that Johnson informed him that the premium payments would have to come from the Ed's Tire Center bank account. It is not clear from the record whether use of this means of payment was an absolute requirement imposed by Mid-West or whether it was simply requested as a convenience to the insurer and to the participating employees. In any event, Hurt agreed to this payment arrangement. In addition, in order to help the employees purchase the insurance and to provide an incentive for them to do so, Hurt decided to contribute $75 toward the cost of the monthly premium for each employee choosing to participate. Hurt wrote a check for the full amount of the first premium payment for each of the two participating employees and then deducted the cost of the premium, less his $75 contribution, from each of the employees' paychecks. This process was repeated each month, with Hurt deducting the participating employees' share of the premium from their pay and permitting Mid-West to debit the Tire Center account for that amount, supplemented by his $75 contribution. Hurt testified that he did not intend to set up an insurance plan or an employee benefit program. Hurt did not comply with any ERISA reporting requirements.

A representative of Mid-West testified that although the major medical policy was considered a "group policy," the only underwriting criterion was the medical eligibility of the individuals to be insured. Mid-West

regarded the Randols as individual applicants for insurance. The insurer never sought or received any application from Ed's Tire Center and Bruce Randol's application mentioned the Tire Center only for the purpose of noting his place of employment. Had the Tire Center failed to make a premium payment, Mid-West would have contacted the Randols rather than the company about the delinquency. When the policy was canceled, Mid-West sent the refund check directly to the Randols.

II. DISCUSSION

In enacting ERISA, Congress established a regulatory regime governing "employee benefit plan[s]." 29 U.S.C. § 1003. Subject to certain statutory exceptions, 29 U.S.C. § 1144(b), none of which are implicated in this case, ERISA "supersede[s] any and all state laws insofar as they . . . relate to any employee benefit plan." 29 U.S.C. § 1144(a). *See Metropolitan Life Insurance Co. v. Taylor,* 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). Whether the instant insurance dispute falls within ERISA's preemptive scope depends on whether the insurance policy at issue qualifies as an "employee benefit plan" for ERISA purposes. The statute defines the term "employee benefit plan" as including, *inter alia,* any "employee welfare benefit plan," 29 U.S.C. § 1002(3), which the statute in turn defines as

> mean[ing] any plan, fund or program . . . established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical or hospital care

> or benefits, [or various other enumerated categories of benefits].

29 U.S.C. § 1002(1). This statutory definition of an ERISA employee welfare benefit plan has been fleshed out through a combination of agency regulations and case law. The Department of Labor, which under 29 U.S.C. § 1135 is empowered to promulgate rules interpreting ERISA, has issued "safe harbor" regulations. These regulations provide that group insurance offered to workers through their place of employment will *not* be deemed an ERISA plan if the insurance program satisfies certain enumerated criteria.[2] However, the insurance program at

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[2] The safe harbor regulations provide as follows:

Certain group or group-type insurance programs.

For purposes of title I of the Act in this Chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs, and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any

issue in this case plainly does not fall within this exception as it does not satisfy the regulations' requirement that the employer not subsidize the purchase price of the insurance. *See* 29 C.F.R. § 2510.3-1(j)(1) (1992).

The Labor Department's safe harbor regulations clarify that group insurance programs meeting certain requirements definitely do not qualify as ERISA plans. The courts have also placed their own construction on the 29 U.S.C. § 1002(1) statutory definition of an ERISA employee welfare benefit plan, establishing criteria for determining whether a given program qualifies as an ERISA plan.[3] Interpreting § 1002(1), the Eleventh circuit has stated that

> To be an *employee* welfare benefit plan, the intended benefits must be health, accident, death or disability, unemployment or vacation

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> profit, for administrative services actually rendered in connection with the payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j) (1992).

[3] It remains an unsettled legal question whether the safe harbor regulations' description of group insurance programs excluded from the ERISA welfare plan definition is exhaustive – i.e., whether *all* group insurance programs that (1) meet the threshold definitional requirements for a "plan, fund, or program" under 29 U.S.C. § 1002(1), *see infra* slip op. pp. 1579-1580, and that (2) fall outside of the safe harbor exception necessarily qualify as ERISA employee welfare benefit plans under § 1002(1). It is not necessary for us to resolve this question in order to decide this case. As the instant insurance program clearly falls both outside of the scope of the safe harbor exception and within the case law definition of an ERISA welfare plan, the program qualifies as an ERISA plan regardless of whether the regulations' exception is exhaustive.

> benefits; the intended beneficiaries must include union members, employees, former employees or their beneficiaries; and an employer or employee organization, or both, and not individual employees or entrepreneurial businesses, must establish or maintain the plan, fund or program.

Donovan v. Dillingham, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (emphasis in original). There is no question that the insurance policy at issue in this case provides health benefits and that the policy's beneficiaries include employees. Elaborating on the meaning of the term "plan, fund, or program" as used in the § 1002(1) statutory definition, the *Donovan* en banc court continued:

> [A] "plan, fund, or program" [exists] under ERISA . . . if from the surrounding circumstances a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits.

688 F.2d at 1373. The purchase of insurance at issue in this case fits within this definition of a § 1002(1) "plan, fund, or program." The intended benefits are, of course, the medical care provided under the insurance policy. The class of beneficiaries is composed of the workers who chose to purchase the group health insurance.[4] The

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[4] This "class" is quite small, being composed of only two persons – Bruce Randol and the one other Ed's Tire Center employee who chose to participate. However, this court has previously held that for the purposes of the *Donovan* definition of an ERISA plan, the requirement that there exist an identifiable class of beneficiaries is satisfied even if the benefit in ques-

source of financing is the employee-paid premium supplemented by the monthly $75 employer contribution. Finally, the procedures for receiving benefits are those set out in the insurance policy.[5]

Since the instant insurance plan qualifies as a "plan, fund, or program," as that term is used in § 1002(1), then whether the plan satisfies the full § 1002(1) definition of an ERISA employee welfare benefit plan depends on whether it was "established or maintained by [the] employer." We hold that through his actions the employer in this case has "maintained" the plan within the meaning of ERISA.[6] The employer wrote the first check purchasing the policies, established a system whereby the premiums would be paid monthly by means

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tion is conferred on only a single person. *See Williams v. Wright*, 927 F.2d 1540, 1545 (11th Cir.1991).

[5] In *Donovan* the en banc court held that there is no requirement that the employer play any role in administering the plan in order for it to be deemed an ERISA employee welfare benefit plan. Thus a commercially purchased insurance policy under which the procedures for receiving benefits are all dictated by the insurance carrier can constitute a plan for ERISA purposes. *Donovan*, 688 F.2d at 1374. *See International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297-98 (6th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S.Ct. 2941, 119 L.Ed.2d 565 (1992); *Brundage-Peterson v. Compcare Health Services Ins. Corp.*, 877 F.2d 509, 510-11 (7th Cir.1989). Indeed, the § 1002(1) definition expressly contemplates and encompasses benefits "provid[ed] . . . through the purchase of insurance."

[6] Having found that the employer has "maintained" the plan, we need not decide whether his degree of involvement in setting up the insurance program at the outset was sufficient for him to be deemed to have "established" the plan as well within the meaning of 29 U.S.C. § 1002(1).

of a bank draft on the corporate account, contributed $75 per employee per month toward the premiums, and collected from the employees the balance of the premiums through a withholding system. Moreover, the employer did the foregoing in order to facilitate his employees' obtaining health coverage. We find that these undisputed facts amply demonstrate that the employer "maintained" the plan. Thus, the insurance policy at issue in this case qualifies as an ERISA employee welfare benefit plan under 29 U.S.C. § 1002(1).

Appellants cite *Taggart Corp. v. Life and Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir.1980), *cert. denied*, 450 U.S. 1030, 101 S.Ct. 1739, 68 L.Ed.2d 225 (1981),[7] as authority for the proposition that the "bare" purchase of a health insurance policy cannot constitute establishment or maintenance of an ERISA employee welfare benefit plan. However, *Taggart* was subsequently limited by the opinion of the *Donovan* en banc court which stated:

> Although we agree with the holding in *Taggart*, we find the reasoning of the opinion that Taggart Corporation did not have a "plan, fund or program" encourages too broad an interpretation. If *Taggart* is interpreted to mean ERISA does not regulate purchases of health insurance when there is no welfare plan, we agree. The purchase of insurance is only a method of implementing a plan, fund, or program and is evidence of the existence of a plan but is not

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[7] Decisions of the former Fifth Circuit handed down prior to October 1, 1981, are binding precedent in the Eleventh Circuit. *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir.1981) (en banc).

> itself a plan. If *Taggart* implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a [multiple employer trust] to provide health insurance to its employees or members cannot be said to have established or maintained an employee benefit plan, we disagree. To that extent *Taggart* shall no longer be binding in the Eleventh Circuit.

Donovan, 688 F.2d at 1375. Thus, *Donovan* limited *Taggart* to its facts. The employer in *Taggart* had simply informed its employees of the availability of group health insurance and had established a system whereby the monthly premium would be deducted from the paycheck of the one employee who chose to participate. Participation was voluntary and the employer did not subsidize purchase of the policy. *See Wickman v. Northwestern National Insurance Co.*, 908 F.2d 1077, 1082-83 (1st Cir.), *cert. denied*, 498 U.S. 1013, 111 S.Ct. 581, 112 L.Ed.2d 586 (1990) (describing facts of *Taggart*). In *Donovan*, we agreed that the employer's actions in *Taggart* did not constitute "maint[enance]" of an ERISA plan. Indeed, the *Taggart* plan would appear to be excluded from the ERISA welfare plan definition under the Labor Department's safe harbor regulations. The facts of the instant case differ significantly from those of *Taggart* in that here the employer not only established a system for withholding premiums from employee wages and paying them directly to the carrier, but he also contributed $75 per employee toward the monthly premium and did so for the purpose of helping the employees obtain health insurance coverage. We hold that such conduct constitutes "maint[enance of] such conduct constitutes

"maint[enance of] . . . [a] plan, fund, or program . . . for the purpose of providing[,] . . . through the purchase of insurance[,] . . . medical, surgical, or hospital care or benefits" within the meaning of 29 U.S.C. § 1002(1).

III. CONCLUSION

Because the insurance program at issue in this case qualifies as an ERISA employee welfare benefit plan under 29 U.S.C. § 1002(1), appellants' state law claims "relate to [an ERISA] employee benefit plan" and therefore are preempted under 29 U.S.C. § 1144(a). The district court thus acted properly in dismissing those claims.

AFFIRMED.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

LINDA RANDOL, et al.,

Plaintiffs,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE, et al.,

Defendants.

CIVIL ACTION NO. 91-0589-RV-S

ORDER

This matter is before the court on defendant Mid-West National Life Insurance Company's ("Mid-West") "motion to dismiss" and the memoranda of law and other materials submitted in support thereof (tabs 3, 4, and 18), defendant Mid-West's "motion to strike jury demand" and the memorandum of law submitted in support thereof (tabs 5 and 6), plaintiffs' "motion to strike" and all materials submitted in support thereof (tabs 10 and 22), plaintiffs' "motion to tax costs" and brief submitted in support thereof (tabs 20 and 21), and defendant Mid-West's "brief in opposition to plaintiff's [sic] motion to tax costs" (tab 23). After due and proper consideration of the foregoing, the court **ORDERS, ADJUDGES, AND DECREES** as follows:

1. The causes of action contained in plaintiffs' complaint state common law claims against defendant Mid-West essentially for the nonpayment by Mid-West of medical benefits under a health insurance plan. Because the insurance plan, in the court's opinion, qualifies as an

"employee welfare benefit plan," within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, plaintiffs' state common law tort and contract claims are preempted by ERISA. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987); *Amos v. Blue Cross and Blue Shield*, 868 F.2d 430 (11th Cir. 1989). Plaintiffs' exclusive remedy is an appropriate action brought under the civil enforcement provisions of ERISA *See* 29 U.S.C. § 1132.

2. In light of the foregoing, the court concludes that defendant Mid-West's "motion to dismiss" and "motion to strike jury demand" are due to be, and hereby are **GRANTED** and, further, that plaintiffs' "motion to strike" and "motion to tax costs" are due to be, and hereby are, **DENIED.**[1] This case shall be dismissed, without prejudice, fourteen (14) days from the date of this order unless plaintiffs, prior to that time, file an amended complaint which sets forth claims for relief under ERISA.

The Clerk of Court hereby is requested to notify all counsel of record for the parties of this order forthwith by telephone.

DONE this the 11th day of October, 1991.

/s/ Richard W. Vollmer, Jr.
UNITED STATES DISTRICT JUDGE

---

[1] Plaintiffs' "motion for leave to file brief in support of motion to strike at the conclusion of scheduled discovery" (tab 11) and "motion for leave to file deposition excerpts and documents in support of plaintiffs' brief in support of motion to strike" (tab 19) are due to be, and hereby are, **GRANTED.**

APPENDIX C

RECORD ATTRIBUTIONS TO UNDISPUTED FACTS

As noted by the Eleventh Circuit panel's opinion (App. at 2a) "the material facts relevant to the ERISA preemption issue are not in dispute." Indeed, the Randols are essentially satisfied with the Eleventh Circuit's characterization of the facts. [App. at 2a-4a]. The Randols take exception with just two of the Eleventh Circuit's observations. First, the opinion recites "it is not clear from the record whether use of this means of payment (debiting Ed's Tire Center's bank account) was an absolute requirement imposed by Mid-West or whether it was simply requested as a convenience to the insurer and to the participating employees." [App. at 3a]. However, it was undisputed by the parties that the pre-printed automatic payment authorization form *expressly states* that Ed's Tire Center authorized such automatic payment "as a convenience to me". [R1-19-54; R1-18-46]. Mid-West's manager of underwriting, Marion Parrotta, admitted that the whole purpose of having the insurance premiums drawn from the account of Mr. Randol's employer was as a matter of convenience. [R1-19-54].

Second, the opinion characterizes Mr. Hurt's contribution of seventy-five ($75.00) dollars monthly as a decision made "in order to help the employees purchase the insurance and to provide an incentive for them do so." [App. at 3a]. Actually, there was conflicting testimony on this point. Mr. Hurt characterized the seventy-five ($75.00) dollars as a raise paid in consideration of employment. [R1-19-18-19]. Moreover, Mr. Hurt did not

pay this money to induce Mr. Randol to buy *this* insurance. To the contrary, Mr. Hurt testified that he agreed to the contribution if Mr. Randol would buy his *own* insurance. [R1-19-11].

Several additional undisputed facts also merit this Court's attention. By stipulation of the parties entered upon the record, Mid-West asserted that it was relying only upon Mr. Hurt's contribution of seventy-five ($75.00) dollars per month as the reason why this transaction constituted an ERISA "employee welfare benefit plan". [R1-19-62]. The stipulations recite that "there is no written document for a trust plan", there is no "specifically designated fiduciary pursuant to a written document", "there is no written document which designates a trustee", "there was no documentation or forms filled out to the Department of Labor . . . by either Ed's Tire Center or by Mid-West", there was "no compliance with any federal regulations", "participation in the group medical coverage was completely voluntary for the plaintiff" (within the meaning of 29 C.F.R. § 2510.3-1(j)(b)), "the sole function of the employer was, without endorsing the program, to permit the insured to publicize the program to the employees, to collect premiums through payroll deductions, and to remit them to the insurer" (pursuant to 29 C.F.R. § 2510.3-1(j)(c)), and Ed's Tire Center "received no cash or other consideration in connection with the program whatsoever" (pursuant to 29 C.F.R. § 2510-3-1(j)(d)). [R1-19-61-64].

It is also undisputed that there was *no "plan administrator"* within the meaning of 29 U.S.C. § 1002(16)(b), [R1-19-24-29-33-40]; there was *no "plan fiduciary"* within the meaning of 29 U.S.C. § 1102(a)(1) and (2), [R1-18-23;

R1-19-24-32-33]; there was *no "trust"* established by the employer within the meaning of 29 U.S.C. § 1102(a), [R1-18-23; R1-19-32-33]; the *employer had no duties of disclosure or reporting* within the meaning of 29 U.S.C. § 1021(a), [R1-18-23; R1-19-34-35]; neither Ed's Tire Center or Mid-West provided *any annual reports or financial statements* concerning the putative "plan" to any "plan participants", the Randols, or the Department of Labor pursuant to 29 U.S.C. § 1023(1)(A), (B), [R1-19-14-15-55]; and, there were *no administrative or reporting responsibilities* imposed upon Ed's Tire Center, [R1-19-14-15-24-39-55].

Ed's Tire Center *never received a copy of the insurance policy.* [R1-19-56-14]. In fact, Ed's Tire Center *never had any correspondence whatsoever* with Mid-West. [*Id.*].

According to Mid-West's manager of underwriting there was *no requirement* that Mr. Randol's employer (or any employer for that matter) be involved *to any degree* with an individual's, like Mr. Randol's, purchase of Mid-West's insurance policy. [R1-19-34-35-39-50]. The sole underwriting criterion concerning the sale of this insurance was a medical qualification, which Mr. Randol satisfied. [R1-19-38-57-58]. It made no difference to Mid-West whether Mr. Randol purchased this insurance individually, through an employer, or through some group. [R1-19-38-57]. This individual sale of a policy to Mr. Randol was *not* considered as "Ed's Tire Center's insurance plan", even by Mid-West. [R1-19-47-48]. Mid-West did not know *or care* whether Ed's Tire Center was actually paying the premiums or whether the full amount of the premiums were being deducted from Mr. Randol's paychecks. [R1-19-52]. Had a premium payment been

missed, Mid-West would have contacted the Randols about the delinquency, *not* Ed's Tire Center. [R1-19-55].

Of course, the Eleventh Circuit's opinion concludes that Mr. Hurt and/or Ed's Tire Center "maintained" an employee welfare benefit plan. It is interesting to compare this conclusion with Mr. Hurt's views on the matter. For example, Mr. Hurt testified that he had no involvement *whatsoever* with the Randols' purchase of the insurance other than reluctantly consenting to Mid-West's debiting of his company's checking account as a matter of convenience. [R1-19-8]. In fact, Mr. Hurt first objected to the debiting of his account, ("but I decided that if the employees – are willing to go ahead and *get insurance for themselves*, I would go along with that side of it"). [R1-19-8]. When Mid-West's salesman initially approached Mr. Hurt about buying the insurance for his employees, Mr. Hurt responded that he as not interested: "I told him (Dan Johnson) that we as a corporation were not interested in group insurance." [R1-19-6]. Likewise, when the salesman asked if he could speak with the employees in the garage, Mr. Hurt consented . . . but he "wasn't endorsing Mid-West insurance or anything like that. I didn't know Mid-West insurance." [R1-19-10-11]. Of course, Mr. Hurt had no idea what he was getting himself into when, at the request of Mid-West's salesman, he reluctantly authorized the debiting of his account:

> "Q: Did you understand that you were setting up some sort of insurance plan, then?
>
> "A: No. And I had no intention of setting up an insurance plan.
>
> "Q: O.K.

"A: Or had no intention of making it any kind of employee benefit."

* * *

"Q: O.K. Did you make clear to Johnson, when he was there, when he was talking to you about this draft on your account, that you didn't want to have any involvement in the insurance except for the payment of the premium?

"A: Yes. That's true.

"Q: Well, tell me about that, that dialogue between you and him about the insurance and your involvement in it."

* * *

"A: My conversation with Johnson was very little because he was talking primarily to the employees and really about the only time he really talked to me was when he said I need a check for the first payment and he will need to draft my bank account.

"Q: For future payments?

"A: Yes.

"Q: O.K. But aside from that, you were to have no other involvement?

"A: Yes. I would hope that I wasn't."

[R1-19-12-13].

Mid-West's salesman, Johnson, and its manager of underwriting, Parrotta, know nothing of ERISA. [R1-19-22-32-33]. Mid-West provided no training or education on the subject whatsoever. [*Id.*]. Of course, Johnson never made any mention to Mr. Hurt, Ed's Tire Center, or

Mr. Randol about ERISA, the Act's requirements, or its consequences at the time of this transaction. [R1-19-23-24-25-28]. Likewise, neither the policy brochure nor the policy itself contain *any mention* of ERISA, the Act's obligations, or its consequences. [R1-18-24-27].

Supreme Court, U.S.
FILED
AUG 11 1993
OFFICE OF THE CLERK

No. 93-77

(2)

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

LINDA RANDOL AND BRUCE RANDOL, JR.,
Petitioners,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

---

BRIEF OF RESPONDENT IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

1. Whether an employer "established or maintained" an "employee welfare benefit plan" subject to the Employee Retirement Income and Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA") when the employer (1) allowed a representatives of the insurer to discuss the coverage at the place of employment and on company time; (2) paid the first month premiums for its employees who chose to participate; (3) contributed $75 per month per employee to help defray costs of health coverage for its employees and to provide an incentive for the employees to obtain health coverage; (4) established a payroll deduction program to collect the remaining balance of the premiums for coverage for its employees and their dependents; and (5) allowed the insurer to draft the corporate bank account to pay the premiums for coverage.

RULE 29.1 STATEMENT

Mid-West National Life Insurance Company of Tennessee is a subsidiary of United Insurance Companies, Inc.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-77

LINDA RANDOL AND BRUCE RANDOL, JR.,
Petitioners,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

---

BRIEF OF RESPONDENT IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

Respondent Mid-West National Life Insurance Company of Tennessee ("Mid-West"), respectfully requests that this Court deny the petition for writ of certiorari to review the judgment of the United States Court of Appeals for the Eleventh Circuit.

INTRODUCTION

Petitioners ask this Court to overrule the *en banc* decision by the Eleventh Circuit in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) (*en banc*) on the basis that a conflict exists between *Donovan* and decisions from other circuits. There is no such conflict, however, inas-

much as the First,[1] Third,[2] Fifth,[3] Sixth,[4] Seventh,[5] Eighth,[6] Ninth [7] and Tenth [8] Circuits *all* have followed the test established in *Donovan* concerning whether a "plan" exists. No contrary decision has been rendered by any circuit which has addressed the issue. A number of United States District Courts also have followed the *Donovan* test.[9] Petitioners, however, invite the Court to

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[1] *See Wickman v. Northwestern Nat. Ins. Co.*, 908 F.2d 1077 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990).

[2] *See Deibler v. United Food & Commercial Workers' Local Union 23*, 973 F.2d 206 (3d Cir. 1992).

[3] *See Meredith v. Time Ins. Co.*, 980 F.2d 352 (5th Cir. 1993); *Hansen v. Continental Ins. Co.*, 940 F.2d 971 (5th Cir. 1991); *Kidder v. H & B Marine, Inc.*, 932 F.2d 347 (5th Cir. 1991); *Gahn v. Allstate Life Ins. Co.*, 926 F.2d 1449 (5th Cir. 1991); and *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d (5th Cir. 1990).

[4] *See Fugarino v. Hartford Life & Acc. Ins. Co.*, 969 F.2d 178 (6th Cir. 1992), *cert. denied*, —— U.S. ——, 113 S. Ct. 1401, 122 L.Ed.2d 774 (1993); *International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294 (6th Cir. 1991), *cert. denied*, —— U.S. ——, 112 S. Ct. 2941, 119 L.Ed.2d 565 (1992); *Brown v. Ampco-Pittsburgh Corp.*, 876 F.2d 546 (6th Cir. 1989).

[5] *See James v. National Business Sys.*, 924 F.2d 718 (7th Cir. 1991).

[6] *See Harris v. Arkansas Book Co.*, 794 F.2d 358 (8th Cir. 1986).

[7] *See Scott v. Gulf Oil Corp.*, 754 F.2d 1499 (9th Cir. 1985).

[8] *See Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043 (10th Cir. 1992); *Roe v. General Am. Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983).

[9] *See, e.g., Moeller v. Bertrang*, 801 F. Supp. 291 (D.S.D. 1992); *Allmendinger v. Aetna Life Ins. Co.*, 804 F. Supp. 432 (D. Conn. 1992); *Sims v. Lumbermens Mut. Casualty Co.*, 789 F. Supp. 781 (S.D. Miss. 1992); *McCaslin v. Blue Cross & Blue Shield of Ala.*, 779 F. Supp. 1312 (N.D. Ala. 1991); *Miller v. National Brokerage Servs.*, 782 F. Supp. 1440 (D. Nev. 1991); *Thomas v. Burlington Indus.*, 763 F. Supp. 1570 (S.D. Fla. 1991); *Walters v. Pan Am. Life Ins. Co.*, 800 F. Supp. 436 (S.D. Miss. 1990); *Garred v. General Am. Life Ins. Co.*, 723 F. Supp. 1325 (W.D. Ark. 1989), *appeal*

adopt the holding of *Taggart Corp. v. Life & Health Benefits Administration*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied, sub nom. Taggart Corp. v. Efros,* 450 U.S. 1030 (1981), a pre-*Donovan* decision by the Fifth Circuit which later was expressly limited to its facts by the Fifth Circuit itself in *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir. 1990).

JURISDICTION

Mid-West agrees with petitioners' statement concerning jurisdiction.

STATUTES AND REGULATION INVOLVED IN THE CASE

1. United States Code, 29 U.S.C. § 1002(1) provides, in pertinent part:

> The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing its participants or their beneficiaries, *through the purchase of insurance* or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions or retire-

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denied, 902 F.2d 1576 (8th Cir. 1990); *James v. National Business Sys.*, 721 F. Supp. 169 (N.D. Ind. 1989), *vacated on other grounds*, 924 F.2d 718 (7th Cir. 1991); *McIntyre v. Okurowski*, 717 F. Supp. 10 (D. Mass. 1989); *Dodd v. John Hancock Mut. Life Ins. Co.*, 688 F. Supp. 564 (E.D. Cal. 1988); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F. Supp. 1497 (W.D. La. 1987); and *Blue Cross & Blue Shield of Ala. v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258 (N.D. Ala. 1983).

ment or death, and insurance to provide such pensions).

29 U.S.C. § 1002(1) (emphasis added).

2. United States Code, 29 U.S.C. § 1132(a)(1)(b) provides, in pertinent part:

> A civil action may be brought—
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of his section, or
>
> (B) the recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan;

29 U.S.C. § 1132(a)(1)(B).

3. United States Code, 29 U.S.C. § 1132(e)(1) provides, in pertinent part:

> Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

29 U.S.C. § 1132(e)(1).

4. United States Code, 29 U.S.C. § 1144(a) provides, in pertinent part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

29 U.S.C. § 1144(a).

5. The Department of Labor's Safe Harbor regulation provides, in pertinent part:

> (j) Certain group or group-type insurance programs. For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employee or members of an employee organization, under which
>
> (1) no contributions are made by an employer or employee organization;
>
> (2) participation in the program is completely voluntary for employees or members;
>
> (3) the sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) the employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j) (1992).

STATEMENT OF THE CASE

A. Course of Proceedings Below

Mid-West agrees with petitioners' statements concerning the course of the proceedings below.

B. Facts Relevant to ERISA Issue

Mid-West does not agree with petitioners' statements concerning the facts relevant to the issues presented in

this petition. For the sake of brevity, Mid-West refers the Court to the statement of facts contained in the Eleventh Circuit's opinion set forth in Appendix A to the Petition for Writ of Certiorari.

C. The Eleventh Circuit's Decision

Contrary to petitioners' statement, the Eleventh Circuit thoroughly examined all of the facts and circumstances before determining that the employer established or maintained a plan. Petitioners' arguments ignore the Eleventh Circuit's opinion in this case, wherein the court stated:

> Since the instant insurance plan qualifies as a "plan, fund, or program," as that terms is used in § 1002(1), then whether the plan satisfies the full § 1002(1) definition of an ERISA employee welfare benefit plan depends on whether it was "established or maintained by [the] employer." We hold that *through his actions the employer in this case has "maintained" the plan within the meaning of ERISA*. The employer wrote the first check purchasing the policies, established a system whereby the premiums would be paid monthly by a means of a bank draft on the corporate account, contributed $75 per employee per month toward the premiums, and collected from the employees the balance of the premiums through a withholding system. Moreover, the employer did the foregoing in order to facilitate his employees' obtaining health coverage. We find these undisputed facts amply demonstrate that the employer "maintained" the plan.

Petition for Writ of Certiorari at 8a-9a (emphasis added). This language refutes petitioners' assertions that the Eleventh Circuit failed to thoroughly examine the employer's conduct or intent. Additionally, contrary to petitioners' contention that the employer did "virtually nothing . . . [except] check [my] statement once a month to see that the premium had been deducted" (Petition for Writ of Certiorari at 4), the undisputed facts established the

employer paid the first month's premiums, contributed $75 per month, established a payroll deduction program and allowed the corporate bank account to be drafted.

SUMMARY OF ARGUMENT

Contrary to petitioners' contentions, this decision and *Donovan* are not in conflict with any decision by this Court or the Fifth Circuit's decision in *Hansen*. The *Donovan* test has been adopted and followed by nine of the twelve Circuit Courts of Appeal. Inimical to petitioners' assertions, the *Donovan* test has not been rejected, either explicitly or implicitly, by a single circuit court of appeals. Petitioners also have misconstrued the Eleventh Circuit's opinion in this case. The Eleventh Circuit did not hold that, simply because the *Donovan* test [10] had been satisfied, the plan was automatically an ERISA plan. Instead, the Eleventh Circuit, after holding a plan existed, analyzed the employer's involvement to determine whether the plan was an ERISA plan. Accordingly, this petition presents no "special and important reasons" justifying granting the writ as required by Rule 10.1. S.Ct. R. 10.1.

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[10] In *Donovan*, the Eleventh Circuit held:

> In determining whether a plan, fund or program (pursuant to a writing or not) is a reality a court must determine whether from the surrounding circumstances a reasonable person could ascertain the intended benefits, beneficiaries, source of financing, and procedures for receiving benefits.

Donovan, 688 F.2d at 1373.

ARGUMENT

I. THERE IS NO CONFLICT BETWEEN THE ELEVENTH CIRCUIT'S HOLDING AND ANY APPLICABLE DECISION OF THIS COURT

Petitioners misinterpret this Court's decisions in *Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1 (1987), and *Massachusetts v. Morash,* 490 U.S. 107 (1989), in an attempt to invent a conflict between those decisions and the Eleventh Circuit's holding in this case.

In *Fort Halifax,* this Court addressed whether ERISA preempted a Maine statute, which required a one-time severance payment in the event of a plant closing. *Fort Halifax,* 482 U.S. at 3-4. This Court held ERISA preemption did not apply because the statute neither established nor required an employer to "maintain" an "employee welfare benefit plan." *Id.* at 6. The basis for this Court's decision was:

> The Maine statute neither establishes, nor requires an employer to maintain, an employee benefit *plan.* The requirement of a one-time lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation. *The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer's obligation is predicated on the occurrence of a single contingency that may never materialize.* The employer may well *never* have to pay the severance benefits. To the extent that the obligation to do so arises, satisfaction of that duty involves only making a single set of payments to employees at the time the plant closes. To do more than write a check hardly constitutes the operation of a benefit plan. Once this single event is over, the employer has no further responsibility. The theoretical possibility of a one-time obligation in the future simply creates no

> need for an ongoing administrative program for processing claims and paying benefits.

Id. at 12 (emphasis added in part). Not only is *Donovan* not in conflict with *Fort Halifax,* this Court in *Fort Halifax* expressly cited *Donovan* for the proposition that a decision to extend benefits was not the establishment of a plan. *Id.* at 12, n.6.

In the case *sub judice,* the employer did more than write a check for a one-time lump-sum payment. The employer wrote a check for the first month's premiums; contributed $75 per month per employee; established a payroll deduction program to collect the remaining balance of the premiums from the employees; and allowed the company bank account to be drafted to pay the premiums. By doing so, the employer assumed a responsibility to pay certain benefits on a regular basis, i.e. $75 per month per employee. The Eleventh Circuit correctly held that the type of employer activity present in this case constituted "maintenance" of a plan and involved a great deal more than "writing a check." Therefore, the Eleventh Circuit's decision was correct and does not conflict with *Fort Halifax.*

In *Morash,* this Court addressed whether ERISA preempted a Massachusetts statute requiring an employer to pay unused vacation time to a discharged employee and imposing criminal sanctions for violations of the statute. *Morash,* 490 U.S. at 109. This Court held ERISA did not preempt the statute and stated:

> Because ordinary vacation payments are typically fixed, due at known times, and do not depend on contingencies outside the employee's control, they present none of the risks that ERISA is intended to address. If there is no danger of defeated expectations, it is no different from the danger of defeated expectations for wages for services performed—a danger Congress chose not to regulate in ERISA.

> This conclusion is supported by viewing the reference to vacation benefits not in isolation but in light of the words that accompany it and give the provision meaning. Section 3(1) subjects to ERISA regulation plans to provide medical, sickness, disability, and death benefits, training programs, day care centers, scholarship funds, and legal services. *The distinguishing feature of most of these benefits is that they accumulate over a period of time and are payable only upon the occurrence of an contingency outside the control of the employee.* . . .

Id. at 115-16 (emphasis added).

In *Morash,* the vacation benefits were "fixed, due at known times, and [did] depend on contingencies outside the employee's control." In the present case, although the contributions by the employer were fixed and due at known times, the employee welfare benefit plan at issue was a plan to provide medical, surgical or hospital care benefits, or benefits in the event of sickness. The benefits payable under the plan was not "fixed, due at known times" and payment did depend on contingencies outside the employee's control. The benefits, other than the employer's contribution, were payable only when there was a claim for medical, surgical or hospital care. Such claims were based on contingencies outside the control of petitioners. Accordingly, there is no conflict between the Eleventh Circuit's decision and *Morash.*

II. THERE IS NO CONFLICT BETWEEN THE ELEVENTH CIRCUIT'S HOLDING AND ANY APPLICABLE DECISIONS OF OTHER UNITED STATES COURTS OF APPEALS ON THE SAME MATTER

Petitioners incorrectly argue that the "plan" test established in *Donovan* basically asks "Is there a plan?" and does not examine the employer's involvement in the plan. This argument ignores that the Eleventh Circuit, in the case at bar, first determined a "plan" existed, then examined the employer's involvement to determine whether the plan was indeed an ERISA plan. Moreover, petition-

ers' reliance on *Hansen*[11] and *Taggart*[12] is misplaced. Examination of *Hansen* reveals the Fifth Circuit relied on *Donovan* in rendering its decision and no conflict exists. Additionally, *Taggart* has been limited to its facts not only by the Eleventh Circuit in *Donovan* but by the Fifth Circuit in *Memorial Hospital,*[13] when it adopted *Donovan*'s limitation of *Taggart.*

As regards petitioners' safe harbor argument, there is no dispute that the plan in this case was not exempted from ERISA by the Safe Harbor regulation, 29 C.F.R. § 2151.3-1(j) by reason of the employer's contributions on behalf of the employees. Moreover, petitioners' argument concerning application of the Safe Harbor factors in analyzing the employer's involvement in the plan ignores the Eleventh Circuit's examination of the employer's conduct in the instant case. After determining the safe harbor regulation did not apply and a plan existed, the Eleventh Circuit examined the nature and degree of the employer's involvement in the plan before concluding the plan was an "employee welfare benefit plan" which was "maintained" by the employer and, therefore, subject to ERISA. Petition for Writ of Certiorari at 8a-9a. Consequently, as the opinion itself reveals, there is no merit in the argument that the Eleventh Circuit failed to examine the employer's conduct before deciding the plan was "maintained" by the employer.

Additionally, petitioners erroneously claim the employer did not have any administrative involvement with the plan. The Tenth Circuit has addressed this same argument and stated "[petitioners'] contention that [the employer's] function is not "administrative" appears to arise from the mistaken assumption that an employer does not administer a plan unless he controls eligibility for cover-

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[11] 940 F.2d 971.

[12] 617 F.2d 1208.

[13] 904 F.2d 236.

age and processes claims for benefits under the plan." *Peckham*, 964 F.2d at 1048, n.9. In response, the Tenth Circuit stated:

> We do not believe that *Fort Halifax* requires an employer to exercise control over eligibility or claims —essentially to play the role of an insurer—or even to be in direct contact with the insurer. *An "employee welfare benefit plan" is specifically defined to include employers' provision of benefits "through . . . insurance or otherwise. . . . Presumably, in most instances where an employer provides benefits through the purchase of insurance, the insurer rather than the employer makes determinations regarding eligibility and claims.*

Id. (emphasis added).

Contrary to petitioners' arguments, there is no conflict between the Eleventh Circuit's decision in this case and *Hansen*. Both the present case and *Hansen* relied upon the test established in *Donovan* to determine whether a "plan" existed and, upon determining a plan existed, both decisions examined the employer's involvement in deciding whether the plan was an "employee welfare benefit plan" which was "established or maintained" by the employer. In examining the issues, both circuits consider (1) whether the plan was excluded by the safe harbor regulation; (2) if not excluded, whether a "plan" existed; and (3) if a "plan" existed, whether the plan was "established or maintained" by the employer. The *Hansen* language quoted by petitioners on page 23 demonstrates that the employee welfare benefit plan at issue was subject to ERISA. As to the employer's involvement, the Fifth Circuit stated: "[t]hus, if an employer does no more than purchase insurance for [its] employees, and has no further involvement with the *collection of premiums*, administration of the policy, *or* submission of the claims, [it] has not established an ERISA plan." *Hansen*, 940 F.2d at 978 (emphasis added). In this case, it is undisputed that the employer had further involvement with the

collection of premiums and, a significant factual distinction from *Hansen*, contributed $75 per month per employee to help defray the cost of coverage.

Petitioners' argument misstates the *Hansen* language which states "the evidence must show that the employer had an "intent to provide its employees with a welfare benefit program through the purchase and maintenance of [the] group insurance policy." *Hansen*, 940 F.2d at 978. Such evidence of intent was present in this case and noted by the Eleventh Circuit, which stated: "in order to help the employees purchase the insurance and to provide an incentive for them to do so, [the employer] decided to contribute $75 toward the monthly premium for each employee choosing to participate." Petition for Writ of Certiorari at 3a. Consequently, in the case *sub judice*, the employer had "a purpose to provide health insurance" to its employees. *Hansen*, 940 F.2d at 978. Therefore, the Eleventh Circuit's opinion does not conflict with *Hansen*.

Petitioners' reliance upon *Taggart* [14] is misplaced because *Taggart* has been limited not only by the Eleventh

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[14] *Taggart* is factually distinguishable because in *Taggart* the corporation was providing benefits for its sole employee, who was the President of the corporation and although it is not clear from the facts was probably the sole shareholder. Under the regulations promulgated by the Department of Labor, this plan would have been excluded from ERISA. 29 C.F.R. § 2510.3-3 (1992), provides in pertinent part:

> (a) *General.* This section clarifies the definition in section 3(3) of the term "employee welfare benefit plan" for the purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the action, only employee benefit plans within the meaning of section 3(3) are subject to title I.
>
> (b) *Plans without employees.* For purposes of title I of the Act and this chapter, the term "employee benefit plan"

Circuit in *Donovan* but also by the Fifth Circuit in *Memorial Hospital*, which adopted *Donovan*'s limitation. In *Donovan*, the Eleventh Circuit limited *Taggart* by stating:

> If *Taggart* implies that an employer or employee organization *that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree.* To that extent *Taggart* shall no longer be binding in the Eleventh Circuit.

Donovan, 688 F.2d at 1375 (emphasis added). Likewise, in *Memorial Hospital* the Circuit itself limited *Taggart* and held:

> Although we held in *Taggart* that the purchase of an insurance policy does not, in and of itself, establish the existence of an ERISA plan, we certainly did not hold, contrary to Memorial's argument, that an employer's purchase of health insurance offers no

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shall not include any plan fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called "Keogh" or "H.R. 10" plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered by title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I.

(c) *Employees.* For the purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and . . .

29 C.F.R. § 2510.3-3 (1992).

evidence of an intent to provide such a plan. We agree with the reasoning of the Eleventh Circuit that

> the purchase of insurance does not conclusively establish a plan, fund, or program, but the purchase is evidence of the establishment of a plan, fund, or program; the purchase of a policy or multiple policies covering a class of employees offers substantial evidence that a plan, fund or program has been established.

Donovan, 688 F.2d at 1373.

Memorial Hospital, 904 F.2d at 242. *See also, Kidder,* 932 F.2d at 352-53.

Unlike *Taggart,* petitioners obtained health coverage under a plan where the employer (1) contributed $75 per month per employee; (2) established a payroll deduction program to collect the remaining balance of the premiums from the employees; and (3) allowed Mid-West to draft the company bank account to pay the monthly premiums. Here, there was "an employer-employee-plan relationship that was lacking in *Taggart.*" *Memorial Hospital,* 904 F.2d at 243. Accordingly, there is no conflict between the decisions of the Fifth Circuit and Eleventh Circuit.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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No. 93-77

IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

LINDA RANDOL and BRUCE RANDOL, JR.,
Petitioners,

v.

MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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BRIEF AMICUS CURIAE OF THE AMERICAN COUNCIL OF LIFE INSURANCE IN OPPOSITION TO THE PETITION FOR CERTIORARI

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QUESTION PRESENTED

Whether an employer that, for the purpose of helping its employees obtain health insurance coverage, establishes a premium payment system for, and contributes to the cost of, an insurance policy for its employees "establishes or maintains" an "employee welfare benefit plan" within the meaning of the Employee Retirement Income Security Act of 1974.

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---

BRIEF AMICUS CURIAE OF THE AMERICAN COUNCIL OF LIFE INSURANCE IN OPPOSITION TO THE PETITION FOR CERTIORARI

INTERESTS OF THE AMICUS [1]

The American Council of Life Insurance ("ACLI") submits this brief on behalf of respondent Mid-West National Life Insurance Company of Tennessee. The ACLI is the largest life insurance trade association in the United States, representing the interests of 616 member life insurance companies. The ACLI's members currently hold 95 percent of the life insurance in force in legal reserve life insurance companies in the United States. These members often sell insurance to employers who choose to

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[1] Counsel for all parties have consented to the filing of this amicus brief. Amicus has filed those consents with the Clerk of this Court pursuant to Rule 37.2 of the Rules of this Court.

establish their employee welfare benefit plans through the purchase of insurance.

The ACLI files this brief to provide its unique perspective, based on its broad-based constituency, concerning why the Court should not grant certiorari review in this case. The issue presented in this case—whether an employer's contributions to the cost of an insurance policy for employees, coupled with its establishment of a premium payment system, "establishes or maintains" an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1988 & Supp. III 1991) ("ERISA"), —is thus vitally important to the ACLI's members, but correctly decided by the court below. In other cases before the Court involving ERISA questions that affect its members, the ACLI has participated as an amicus. *See, e.g., Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985).

STATEMENT OF THE CASE

This case concerns the application of the Employee Retirement Income Security Act of 1974, *as amended* ("ERISA"), to an employee welfare benefit arrangement funded, in part, by employer contributions to the cost of an insurance policy purchased from Mid-West National Life Insurance Company of Tennessee ("Mid-West"). Petitioners Bruce and Linda Randol, respectively an employee of Ed's Tire Store, Inc. (the "employer") and his spouse, contend that this arrangement does not constitute an "employee welfare benefit plan" under ERISA and, accordingly, that ERISA does not preempt the state law claims in their complaint. The Eleventh Circuit disagreed. Consistent with the other courts of appeals that have addressed the issue squarely, the Eleventh Circuit held that the employer's welfare benefit arrangement constitutes an ERISA plan.

1. The employer, a small tire franchise in Mobile, Alabama, offered no insurance to its three employees prior to March 1988 (Pet. App. 2a). At that time, while the Randols were apparently seeking medical insurance coverage, an agent of Mid-West met with Mr. Randol on the employer's premises, with the employer's permission, concerning his insurance options (*id.* at 2a-3a). Because of its employees' interest in obtaining insurance from Mid-West, the employer agreed to assist them in the purchase of this insurance. To this end, the employer: (1) wrote a check to Mid-West on its corporate account to cover the initial premium payment for Randol and its other interested employee (*id.* at 3a); (2) agreed to contribute $75 each month toward the monthly premium payments for each of its covered employees (*id.*); (3) agreed to collect the balance of the premium from each covered employee through weekly payroll deductions (*id.*); and (4) signed a bank draft authorization form allowing Mid-West to withdraw the monthly premiums from its account (Pet. Br. 4). The employer did the foregoing "in order to facilitate his employees' obtaining health coverage" (Pet. App. 9a).

Mid-West insured and administered the insurance program, which was considered "group" insurance coverage (Pet. App. 3a). The Randols, therefore, submitted their claims for medical benefits arising from complications with Mrs. Randol's pregnancy to Mid-West. When Mid-West denied the Randols' claim for medical benefits, they sued Mid-West in state court, claiming that this denial constituted a breach of contract, a bad-faith denial of a claim for benefits, and fraud (*id.* at 1a).

2. On July 22, 1991, Mid-West removed this action to federal district court (Pet. App. 1a). On October 11, 1991, the district court dismissed petitioners' state common law tort and contract claims on the grounds that the insurance policy was an "employee welfare benefit plan" within the meaning of ERISA and, therefore, ERISA preempted petitioners' state claims (*id.* at 13a).

The Eleventh Circuit affirmed the district court's decision on April 12, 1993 (Pet. App. 1a, 11a). First, the court held that the employer's insurance arrangement did not fall within the scope of the Department of Labor's safe harbor regulation, which identifies practices that, in the opinion of the Department, do not amount to "establishing" or "maintaining" an ERISA "plan, fund, or program" (*id.* at 6a; see discussion *infra* at 6-7). Next, after noting that it is "unsettled . . . whether the safe harbor regulations' description of group insurance plans excluded from [ERISA] is exhaustive" (*id.* at 6a n.3), the court held that the employer's insurance arrangement was an ERISA § 3(1) "plan," as the Eleventh Circuit defined that term in *Donovan v. Dillingham,* 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (*id.* at 7a-8a). Finally, the court held that the employer "maintained" the plan within the meaning of ERISA by "wr[iting] the first check purchasing the policies, establish[ing] a system whereby the premiums would be paid monthly by means of a bank draft on the corporate account, contribut[ing] $75 per employee per month toward the premiums, and collect[ing] from the employees the balance of the premiums through a withholding system" (*id.* at 8a-9a). The court further noted that "the employer did the foregoing in order to facilitate his employees' obtaining health coverage" (*id.* at 9a).

ARGUMENT

In asking this Court to grant review, petitioners seek to generate decisional conflicts where none exist. The Eleventh Circuit correctly held that the insurance arrangement in this case—where the employer, with the intent of helping its employees obtain health insurance coverage, established a premium payment system for, and contributed to the cost of, a health insurance policy for its employees—constituted an ERISA employee welfare benefit plan. The court recognized that ERISA fully contemplates that employers (and, in particular, small employers) will often establish employee welfare benefit

plans through insurance arrangements and, in doing so, will delegate most of the administrative duties relating to those plans to insurers or outside administrators.

When reviewing this type of insurance arrangement, this Court and the courts of appeals have similarly recognized that employers can—and often do—play limited, yet meaningful, roles in these plans, without removing them from ERISA's expansive reach. Because the Eleventh Circuit's decision is entirely consistent with this uniform understanding, as well as with ERISA's language and underlying policies, there is no good reason for the Court to review it.

I. THE COURT NEED NOT REVIEW THE ELEVENTH CIRCUIT'S DECISION THAT THE EMPLOYER'S INSURANCE ARRANGEMENT IS AN EMPLOYEE WELFARE BENEFIT PLAN BECAUSE IT IS CONSISTENT WITH THE DECISIONS OF OTHER COURTS OF APPEALS AND THIS COURT'S PRECEDENT

Section 3(1) of ERISA, 29 U.S.C. § 1002(1), states that an "employee welfare benefit plan" is:

> any plan, fund, or program which was . . . *established or maintained by an employer* . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical . . . benefits . . .

(emphasis added). The Eleventh Circuit held that the employer in this case satisfied Section 3(1)'s "maintenance" requirement by: (1) writing a check to purchase medical insurance policies from Mid-West; (2) establishing a system whereby the premiums would be paid monthy by means of a bank draft on the corporate account; (3) contributing $75 per employee per month toward the premiums; (4) collecting from the employees the balance of the premiums through a withholding system; and (5) doing all of these things to "facilitate his employees' ob-

taining health coverage" (Pet. App. 9a). This holding and reasoning are fully consistent with the decisions of other courts of appeals and with this Court's precedent, rendering review in this Court unnecessary.

A. The Eleventh Circuit's Analysis of ERISA § 3(1)'s "Established Or Maintained" Requirement Is Fully Consistent With The Analyses Of Other Courts of Appeals

Contrary to petitioners' assertion (Pet. Br. 22-27), there is no meaningful distinction between the Eleventh Circuit's analysis of ERISA's "maintenance" requirement and the analyses of the Fifth, Seventh, and Tenth Circuits. Like the court below, the Fifth, Seventh, and Tenth Circuits all conduct the essential inquiry into the degree of employer involvement in the operation of the plan before subjecting the plan to ERISA regulation.

1. That there is no hard and fast rule for determining the minimum level of employer involvement that will subject an insurance arrangement to ERISA hardly rises to the level of a conflict. This area is not without meaningful guidance. At one end of the spectrum, the Department of Labor has promulgated a regulation that provides a "safe harbor" for insured benefit programs where employer involvement is so minimal that the requisite "establishment or maintenance" activity required for ERISA coverage is absent. *See* Preamble to the Proposed Regulation at 29 C.F.R. § 2510.3-1(j), 40 Fed. Reg. 24,643 (1975). To qualify for this safe harbor:

(1) The employer can make no contributions;

(2) Participation in the program must be completely voluntary for employees;

(3) The employer's sole functions under the program may be to permit the insurer to publicize the program to employees, to collect premiums through payroll deductions and to remit them to the insurer, without taking any action that

could be considered an "endorsement" of the program; and

(4) The employer may not receive any consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation for administrative services actually rendered in connection with payroll deductions.

29 C.F.R. § 2510.3-1(j) (1992). This safe harbor regulation thus ensures that, when an employer's involvement in an insurance arrangement amounts to no more than that of a "passive bystander," the arrangement will not fall within ERISA's regulatory scope.

Beyond this "passive bystander" rule, the courts have uniformly recognized that more meaningful employer involvement will trigger ERISA coverage. They also uniformly recognize that such involvement may take many forms. *See, e.g., Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991) (employer involvement may take the form of "collection of premiums, administration of the policy, *or* submission of claims" (emphasis added)); *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1049 (10th Cir. 1992) (employer "established or maintained" an ERISA plan because it "joined [a multi-employer trust] in order to obtain insurance for its employees, purchased basic insurance . . . for its employees, and listed insurance in its company manual as an employment benefit"); *Brundage-Peterson v. Compcare Health Serv. Ins. Corp.*, 877 F.2d 509, 511 (7th Cir. 1989) (employer's contract with an insurance company to insure employees, establishment of a single eligibility requirement for that insurance coverage, and contribution of the workers' share of the premiums brought the insurance arrangement under ERISA).

These courts also make clear that the employer's involvement in the plan may well be quite minimal—and need not include control over the eligibility for coverage

or participation in processing claims for benefits. Delegation of these functions to an insurer or outside agent is perfectly consistent with the language and purposes of ERISA. *See, e.g., Peckham*, 964 F.2d at 1048 n.9; *Brundage-Peterson*, 877 F.2d at 511; *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 243 (5th Cir. 1990).[2]

2. Petitioners also are mistaken in invoking *Taggart Corp. v. Life & Health Benefits Administration, Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981), as a source of discord between the Fifth and the Eleventh Circuits. In *Taggart*, the Fifth Circuit held that an employer's "bare purchase[] of health insurance" through a Multiple Employer Trust did not establish an ERISA plan under the facts and circumstances of that case. *Id.* at 1211. The court below made clear that the facts in this case "differ significantly from those in *Taggart*" (Pet. App. 10a): unlike the employer in *Taggart*, the employer here "established a system for withholding premiums from employee wages and paying them directly to the carrier, . . . contributed $75 per employee toward the monthly premium and did so for the purpose of helping the employees obtain health insurance coverage" (*id.*).

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[2] *MDPhysicians & Assocs. v. State Bd. of Ins.*, 957 F.2d 178, 185 (5th Cir.), *cert. denied*, 113 S. Ct. 179 (1992), upon which petitioners also rely (Pet. Br. 19), is not to the contrary. In *MDPhysicians*, the court determined whether, by establishing a multiple employer welfare arrangement ("MEWA") within the meaning of ERISA § 3(40), the manager of the MEWA established a single ERISA-covered plan. The court thus examined the question whether the manager was acting on behalf of a group of related employers, which would make the manager an "employer" within the meaning of ERISA § 3(5) and the MEWA a single ERISA-covered plan. The court expressly stated that its decision did not address the question whether any of the subscribing employers themselves established ERISA-covered plans for their employees by subscribing to the MEWA. *MDPhysicians*, 957 F.2d at 182 n.4. *MD Physicians* thus has no relevance to this case.

In any event, in other contexts, both the Fifth Circuit —even after *Taggart*—and the Eleventh Circuit have agreed that the purchase of insurance, without more, may not conclusively establish a plan, fund, or program, but that " 'the purchase of a policy or multiple policies covering a class of employees offers *substantial evidence* that a plan, fund, or program has been established.' " *Memorial Hosp. Sys. v. Northbrook Life Ins. Co.*, 904 F.2d 236, 242 (5th Cir. 1990) (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (en banc) (emphasis added)). *See also Wickman v. Northwestern Nat'l Ins. Co.*, 908 F.2d 1077, 1083 (1st Cir.), *cert. denied*, 498 U.S. 1013 (1990) (same). *Taggart*, then, is not a source of a circuit court split. Even had there been such a conflict, these courts themselves have seemingly resolved it.

3. Petitioners' effort to create a conflict with other circuits, pointing to a heightened "intent" requirement that the court below supposedly did not apply, is similarly misplaced. The Eleventh Circuit twice made clear that the employer participated in the purchase of the insurance policies and the continued operation of the plan "*in order to* facilitate his employees' obtaining health coverage" (Pet. App. 9a (emphasis added)); *see also id.* at 10a. To the extent that the cases upon which petitioners rely might be regarded as purporting to establish an intent requirement, the Eleventh Circuit's analysis more than satisfies it. *See Hansen v. Continental Ins. Co.*, 940 F.2d 971, 978 (5th Cir. 1991) (the evidence must show that the employer had an " 'intent to provide its employees with a welfare benefit program through the purchase and maintenance of [the] group insurance policy' " (citation omitted)); *Ed Miniat, Inc. v. Globe Life Ins. Group*, 805 F.2d 732, 741 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987) ("In the case before us the corporation has, via written agreement, established its intent potentially to provide benefits to all salaried em-

ployees.").[3] Indeed, in *Wickman v. Northwestern Nat'l Life Ins. Co.*, 908 F.2d at 1083, the First Circuit relied on the Eleventh Circuit's analysis in *Donovan v. Dillingham*, 688 F.2d at 1374-75, as an example of how its stated intent requirement works in practice. Petitioners thus have failed to show how the Eleventh Circuit's application of the so-called "intent" requirement meaningfully deviates from the analysis of any of the other courts of appeals.[4]

4. In all events, petitioners' suggestion that a circuit court conflict exists fails to find any support in the words or actions of the very courts on which petitioners seek to rely. Those courts, which supposedly have "implicitly or explicitly rejected the Eleventh Circuit's test" (Pet. Br.

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[3] *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 493 (9th Cir. 1988) (per curiam), *cert. denied*, 492 U.S. 906 (1989), upon which petitioners rely, does not purport to establish an "intent" requirement. In that case, the Ninth Circuit simply noted that evidence existed showing that the plan administrator intended to create an ERISA plan.

[4] Petitioners suggest (Pet. Br. 6), without case law support, that a "plan" does not fall within the purview of ERISA unless an employer has an intent to establish an ERISA-covered plan or satisfies all ERISA requirements. The reason that petitioners find no support for this remarkable proposition is clear: such a requirement would give persons establishing or maintaining such arrangements the ability to circumvent ERISA by either expressly denying any intent to establish a plan or merely failing to perform certain duties required under ERISA. *See Donovan v. Dillingham*, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc); *see also Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1503 (9th Cir. 1985); *Dependahl v. Falstaff Brewing Corp.*, 491 F. Supp. 1188, 1195 (E.D. Mo. 1980), *aff'd in part and rev'd in part*, 653 F.2d 1208 (8th Cir.), *cert. denied*, 454 U.S. 968 and 454 U.S. 1084 (1981). The Eleventh Circuit thus decided correctly (and consistent with the decisions of other courts) that the fact that the employer here had no written plan, denied any intention of creating an ERISA-covered plan, complied with none of the reporting or disclosure requirements of ERISA, appointed no official plan administrator (separate from the insurer), and had no designated plan fiduciaries was irrelevant to the determination of ERISA plan status.

22), repeatedly invoke Eleventh Circuit precedent in support of their reasoning and conclusions. *See, e.g., Kidder v. H & B Marine, Inc.*, 932 F.2d 347, 353 (5th Cir. 1991) (per curiam); *Brundage-Peterson v. Compcare Health Serv. Ins.*, 877 F.2d 509, 511 (7th Cir. 1989); *Peckham v. Gem State Mutual of Utah*, 964 F.2d 1043, 1047 (10th Cir. 1992); *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 (9th Cir. 1988) (per curiam), *cert. denied*, 492 U.S. 906 (1989). And the courts do so without even hinting that they disagree with any part or parts of the Eleventh Circuit's approach.

Even more tellingly, the circuits that are in supposed conflict with the Eleventh Circuit have ruled that insurance arrangements with the same or even less employer involvement than the arrangement at issue here constitute "employee welfare benefit plans." *See, e.g., Roe v. General American Life Ins. Co.*, 712 F.2d 450, 451-52 (10th Cir. 1983) (plan existed where employer made life insurance available to its employees and contributed part of each employee's premium); *Memorial Hosp. Sys. v. Northbrook Ins. Co.*, 904 F.2d 236, 241 (5th Cir. 1990) ("Noffs established and maintained the plan by purchasing the policy and paying the premiums directly to Northbrook"); *Credit Managers Ass'n v. Kennesaw Life & Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) ("Even if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees"). These words and actions plainly contradict the notion that a meaningful conflict exists that this Court must resolve.

B. The Eleventh Circuit's Conclusion That The Employer's Insurance Arrangement Is Governed By ERISA Is Fully Consistent With The Decisions Of This Court.

Petitioners' contention that the decision below conflicts with past decisions of this Court is equally unfounded. As an initial matter, petitioners fail to mention *Metro-*

politan Life Insurance Co. v. Massachusetts, 471 U.S. 724 (1985), in which this Court made clear that insurance arrangements, like the arrangement in this case, generally are "employee welfare benefit plans." *See id.* at 739. Instead, petitioners cite *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), and *Massachusetts v. Morash*, 490 U.S. 107 (1989), neither of which even addresses the issue of how much employer involvement is necessary to bring an insurance arrangement under ERISA. Moreover, to the extent that *Fort Halifax* and *Morash* have any bearing on this case, they support the conclusion that the employer's insurance arrangement here is an ERISA "employee welfare benefit plan."

In *Fort Halifax*, the Court addressed the question whether a Maine statute that required employers to provide a one-time severance payment to employees in the event of a plant closing required an employer to establish or maintain an employee welfare benefit plan. In holding that the statute did not do so, the Court explained that a "plan," as opposed to a mere "benefit," "embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation." *Id.* at 11-12. Under this reasoning, the statute did not require employers to establish or maintain plans because "[t]he theoretical possibility of a one-time obligation in the future simply creates no need for an ongoing administrative program for processing claims and paying benefits." *Id.* at 12.

Like *Fort Halifax*, *Morash* focuses on the nature of the benefits provided, rather than on the employer's involvement in providing those benefits. The Court there considered whether a Massachusetts statute that required employers to pay a discharged employee for unused vacation time on the date of discharge required an employer to establish or maintain an employee welfare benefit plan. The Court held that the statute did not do so, reasoning that: "Because ordinary vacation benefits are typi-

cally fixed, due at known times, and do not depend on contingencies outside the employee's control, they present none of the risks that ERISA is intended to address." *Morash*, 490 U.S. at 115.

The insurance arrangement in this case easily meets the "plan" requirement set out in *Fort Halifax* and *Morash*. Providing medical benefits through Mid-West's insurance policy indisputably involves "a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements." *Fort Halifax*, 482 U.S. at 9. It also implicates the risks that ERISA was designed to address. Nothing in *Fort Halifax* or *Morash* states that some or all of these obligations or risks must be undertaken or borne by an employer, as opposed to an insurer-administrator. *See Brundage-Peterson*, 877 F.2d at 511 ("The contingent feature of a true welfare benefits plan, stressed in . . . *Massachusetts v. Morash*, [490 U.S. 107] (1989) is unaffected by the delegation of administration of the plan to an insurance company—a delegation in fact contemplated by statute").

The Eleventh Circuit's decision in this case thus is fully consistent with the decisions of other courts of appeals and this Court. The courts have given employers (both large and small) ample notice that, by administratively and financially helping their employees to obtain health insurance coverage, the employers may have to submit to ERISA regulation. No further guidance from this Court is necessary.

II. THE COURT NEED NOT REVIEW THE ELEVENTH CIRCUIT'S DECISION BECAUSE IT IS CONSISTENT WITH ERISA'S LANGUAGE AND UNDERLYING POLICIES

This Court's review of the Eleventh Circuit's decision is unnecessary for another reason. The decision below properly interprets ERISA's language and implements its underlying policies, both of which contemplate that employers often will establish employee welfare benefit plans through insurance arrangements like the arrangement at issue in this case.

In enacting ERISA, Congress clearly contemplated that insurers would play vital roles in both funding and administering employer-sponsored welfare benefit programs. ERISA § 3(1) defines an "employee welfare benefit plan" as "any plan, fund, or program which was . . . established or maintained by an employer . . . *through the purchase of insurance or otherwise*" (emphasis added). ERISA's terms also permit the delegation of administrative duties to third parties (such as insurers) without requiring the employer/sponsor to retain any particular duties under the plan (ERISA § 405(c)(1), 29 U.S.C. § 1105(c)(1)); indeed, ERISA's definition of "plan administrator" expressly states that the administrator may be someone other than the employer (ERISA § 3(16)(A), 29 U.S.C. § 1002(16)(A)). These terms and others sprinkled throughout ERISA [5] plainly reflect Congress's intent that

[5] *See, e.g.*, ERISA § 3(38), 29 U.S.C. § 1002(38) (defining the entities that may serve as investment managers for ERISA-covered plans, including any insurance company qualified to perform services under the laws of more than one state); ERISA § 401(b)(2), 29 U.S.C. § 1101(b)(2) (concerning the treatment of assets of an insurer that issues a guaranteed benefit policy to an ERISA-covered plan); ERISA § 403(b)(1) & (2), 29 U.S.C. § 1103(b)(1) & (2) (concerning the exemption from the general trust requirement for those assets of ERISA-covered plans that consist of insurance contracts or policies); ERISA § 408(b)(5), 29 U.S.C. § 1108(b)(5) (concerning the exemption from the prohibited transaction provi-

insurers and their insurance products would play an extensive role in ERISA-covered plans.

The Eleventh Circuit's decision that the employer's insurance arrangement is an employee welfare benefit plan also furthers ERISA's underlying policies. Indeed, to hold that the arrangement is not covered by ERISA would be tantamount to eliminating ERISA coverage for, and denying ERISA protections to, employees of many employers who select insurance as the funding mechanism for their employee benefit arrangements and who delegate the administration of those arrangements to an insurer. The employers who most frequently select insurance as the funding mechanism for their plans and who delegate the administration of those plans to insurers are not large employers; they are small employers, just like Mr. Randol's employer, for whom these types of insurance arrangements to provide benefits to their employees are, as a practical matter, essential.

In fact, a recent study showed that approximately 65 percent of the large employers in the United States self-fund their plans; in contrast, a majority of small employers fund their plans through insurance.[6] Small employers often turn to insurers to provide the benefits under, and to administer, their plans for obvious reasons. They typically do not have the staff, ability or time to

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sions for certain ERISA-covered plans that purchase insurance contracts or annuities from certain insurers); ERISA § 607(1), 29 U.S.C. § 1167(1) (concerning the definition of what constitutes a "group health plan" (an employee welfare benefit plan that provides medical care to participants directly or through insurance, reimbursement, or otherwise) for purposes of determining the applicability of the requirements of Part 6 of ERISA, which extend coverage under group health plans to plan participants after certain coverage terminating events).

[6] A. Foster Higgins & Co., 1988 Foster Higgins Health Care Benefits Survey 23 (1988). A large employer is defined in this study as one with 1,000 or more employees. A small employer is defined as one employing fewer than 1,000 employees.

administer their own plans. They need the broad spreading of risk that a group insurance policy can provide. And they need the efficiencies of scale that an insurer's established claims processing procedure and trained personnel offer.[7]

In enacting ERISA, Congress clearly understood that these special concerns faced small employers and that insurers would thus play a very significant role in ERISA-covered plans. The Eleventh Circuit properly refused to decide that a small employer may not be considered to have either "established or maintained" a "plan" under ERISA, even though it has (1) facilitated its employees' participation in an insured health benefit arrangement by promising them partial premium payments, (2) set up a premium payment procedure that includes giving authorization to the insurer to draw on the employer's corporate bank account for the premium payments, and (3) contributed a significant portion of each premium for payment for each participating employee.

A contrary decision would provide a blueprint to all small employers for precisely how to "opt out" of ERISA regulation. It would be bizarre, indeed, if a small employer could avoid ERISA's reach merely by stating that it does not "intend" to establish an ERISA plan when it contributes to the cost of insurance for its employees, by refusing to comply with any of ERISA's requirements, and by appointing an independent third party (whether an insurer or not) to administer its plan. The Eleventh Circuit properly rejected this unwarranted result and, in the process, rendered a decision entirely faithful to the statute, this Court's decisions, and the decisions of other courts of appeals.

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[7] *See* O. Mitchell & E. Andrews, *Scale Economics in Private Multi-Employer Pension Systems*, 34 Indus. & Lab. Rel. Rev. 522 (1981). This study shows that administrative expenses per participant are over ten times as high for plans with 100 participants as for those with 20,000 participants.

CONCLUSION

The petition for certiorari should be denied.

Respectfully submitted,

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